17/11/2026

ASX Release

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EMV TO PRESENT AT THE BELL POTTER HEALTHCARE CONFERENCE 2026

EMVision Medical Devices Limited (ASX:EMV) ("EMVision" or the "Company") is pleased to advise that CEO and Managing Director Scott Kirkland will present at the Bell Potter Healthcare Conference on 17 November 2026.

A copy of an updated EMVision investor presentation is attached.

The presentation outlines what the Company regards as company defining milestones ahead, including the emu™ pivotal trial readout targeted for mid CY27.

Authorised for release by the Board of the Company.

[ENDS]

For further information, media or investor enquiries, please contact:

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About EMVision Medical Devices

EMVision Medical Devices Limited (ASX:EMV) is an innovative Australian medical device company developing a novel approach to looking inside the human body. Our product pipeline includes portable, non-invasive, affordable and safe neurodiagnostic devices.

Our vision is to help transform and improve the timely diagnosis and treatment of stroke and other time sensitive medical emergencies, at the point-of-care.

EMVision has offices in Sydney and Brisbane www.emvisionmedical.com

About Stroke

Stroke is a medical emergency that occurs when blood flow to part of the brain is interrupted, either by a blocked vessel (ischaemic stroke) or bleeding into the brain (hemorrhagic stroke). The resulting lack of oxygen and nutrients can rapidly damage brain tissue, leading to disability or death if not treated promptly. Different stroke types require different types of care. Early recognition and fast access to diagnosis and appropriate care are critical, as timely intervention can significantly improve outcomes. EMVision is working to make rapid stroke diagnosis possible at the point of care, wherever the patient is.

Forward-looking Statements

This release may contain certain forward-looking statements with respect to matters including but not limited to the financial condition, results of operations and business of EMVision and certain of the plans and objectives of EMVision with respect to these items. These forward-looking statements are not historical facts but rather are based on EMVision's current expectations, estimates and projections about the industry in which EMVision operates, and its beliefs and assumptions. Words such as "anticipates," "expects," "intends," "plans," "believes," "seeks," "estimates", "guidance" and similar expressions are intended to identify forward looking statements and should be considered an at-risk statement. Such statements are subject to certain risks and uncertainties, particularly those risks or uncertainties inherent in the process of developing technology and in the endeavour of building a business around such products and services. These statements are not guarantees of future performance and are subject to known and unknown risks, uncertainties and other factors, some of which are beyond the control of EMVision, are difficult to predict and could cause actual results to differ materially from those expressed or forecasted in the forward-looking statements. EMVision cautions shareholders and prospective shareholders not to place undue reliance on these forward-looking statements, which reflect the view of EMVision only as of the date of this release. The forward-looking statements made in this announcement relate only to events as of the date on which the statements are made. EMVision will not undertake any obligation to release publicly any revisions or updates to these forward-looking statements to reflect events, circumstances or unanticipated events occurring after the date of this announcement except as required by law or by any appropriate regulatory authority.

Inherent risks of Investment in Medical Device development Companies

There are a number of inherent risks associated with the development of new medical device products to a marketable stage. The clinical trial process, which is often lengthy, is designed to assess the safety and efficacy of a device prior to commercialisation and there is no guarantee of achieving the outcomes necessary to generate a viable commercial product. Other risks include uncertainty of patent protection and proprietary rights, the obtaining of necessary regulatory authority approvals and the evolving competitive landscape. Companies such as EMVision are dependent on the success of their research and development projects, product development and on the ability to attract funding to support these activities. Investment in research and development and novel product development cannot be assessed on the same fundamentals as trading and manufacturing enterprises. Therefore investment in Companies specialising in such development must be regarded as speculative. EMVision recommends that professional investment advice be sought prior to such investments and cautions investors that the risks of an investment in an entity such as EMVision is not limited to the risks disclosed in this announcement.

EMVISION

Bringing brain scanning to the patient

Point-of-care scanners for neurological emergencies

EMVision Medical Devices (ASX:EMV)



Disclaimer

ABOUT THIS PRESENTATION

Summary information. This presentation has been prepared by EMVision Medical Devices Ltd (ACN 620 388 230) (EMVision or the Company). It is a summary only, is current at the date of the presentation and does not purport to be complete. It should be read with the Company's ASX announcements.

Not an offer. This presentation is not a prospectus or other offer document. It is not an offer, invitation or recommendation to buy or sell any security in any jurisdiction, including the United States.

Not financial advice. The information is general and does not take into account any person's investment objectives, financial situation or needs. Investors should make their own enquiries and seek professional advice before making an investment decision.

Currency. All amounts are in Australian dollars unless stated otherwise.

FORWARD-LOOKING STATEMENTS

Statements about the future. This presentation includes forward-looking statements, such as the timing and results of clinical trials, regulatory submissions and clearances, product development, commercial launch, market opportunity, grant receipts and funding.

Risks and uncertainties. These statements reflect current expectations and assumptions. They involve known and unknown risks, many outside the Company's control, and actual results may differ materially. Nothing in this presentation is a promise or guarantee of future performance.

Targets only. All timings are targets and may change, including because of patient recruitment rates, trial results, regulatory feedback and funding.

No obligation to update. Except as required by law or the ASX Listing Rules, the Company does not undertake to update any forward-looking statement.

DEVICES, DATA AND LIABILITY

Investigational devices. The emu™ and First Responder brain scanners are investigational devices. They have not been cleared or approved by the US Food and Drug Administration or any other regulator and are not available for sale. Planned regulatory pathways, indications for use and performance claims are subject to agreement with regulators.

Clinical data. Results from earlier studies come from limited sample sizes and are subject to confirmation in the ongoing pivotal trial. Comparisons with other technologies use separate published studies and are indicative only, not head-to-head.

Third-party information. Market, industry and scientific data from third parties has not been independently verified. Third-party names and logos belong to their owners.

No liability. To the maximum extent permitted by law, the Company and its directors, officers, employees and advisers make no representation or warranty about the accuracy or completeness of this presentation and accept no liability for any loss arising from its use.

Company Overview



WHO WE ARE

Late-stage Australian medtech company

- EMVision is developing **portable, non-ionising** brain scanners for bedside and field diagnosis
- Pioneering a **new brain scanner category,** for stroke and traumatic brain injury, targeting unmet clinical needs
- Designed to enable **faster** triage, transfer and potential treatment decisions before brain tissue is lost



STRONG FOUNDATIONS

Built on science, backed by evidence

- **$75m+ invested since 2017**, building on a decade of UQ research
- **15+ patent families**, in-house research, development and manufacturing teams
- **Approximately 50 staff** across Sydney and Brisbane



CORPORATE SNAPSHOT

Established infrastructure

- **$18.1m cash on hand and $3.7m in active grants** as at 30 September 2026
- **Recurring revenue model** across two large markets: device sales, per scan consumables & annual servicing
- **Experienced board & leadership** diverse skillsets across medical devices, healthcare systems & commercialisation

Cash as at 30 September 2026. Refer to the Company's Appendix 4C reports and ASX releases for more information.

Conventional scanners can’t go to the patient

CONVENTIONAL NEUROIMAGING

THE CHALLENGE:

Patients must be taken to the scanner



Large, heavy and fixed
Patients must travel to the scanner

Expensive and complex
High capex/opex, requires specialist staff

Ionising radiation
Requires shielded facilities

Limited access
Typically hospital-based

EMV DEVICES



OUR SOLUTION:

Our scanners go to the patient

Portable and lightweight
Wheeled or carried to the patient

Cost-effective by design
Easy to use, built for frontline care

Non-ionising technology
No shielding, safe for repeat scanning

Access beyond radiology
Assessment at the point of care

EMVision devices are designed to complement CT or MRI and close gaps in access

Not intended as a replacement for CT or MRI

Two devices, one mission

BEDSIDE | ED | ICU | REGIONAL

emu™

Lightweight
A complete brain scanning system on a compact hospital cart

Made for the bedside
Assess patients in ED, ICU and on the wards

Guide care decisions
Support earlier triage, transfer and treatment decisions



SCENE | ROAD | AIR

First Responder

Ultra lightweight
Single paramedic can carry directly to the patient

Made to travel
Battery powered for road and air ambulance deployment

Inform care before arrival
Support hospital selection and notification, and potentially in-field treatment

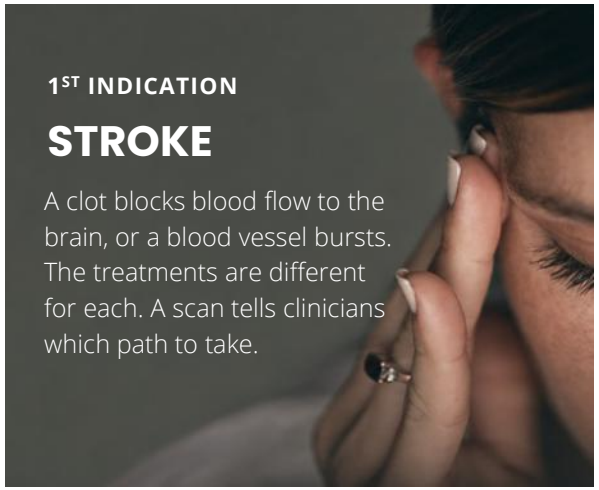


Provide rapid and reliable insights at the point of care to accelerate clinical decision making and reduce time to treatment

emu™ and First Responder are investigational devices and not available for sale. Prototype First Responder pictured; production equivalent unit under development.

Targeting time critical neurological emergencies

EMV TARGET INDICATIONS



1ST INDICATION

STROKE

A clot blocks blood flow to the brain, or a blood vessel bursts. The treatments are different for each. A scan tells clinicians which path to take.

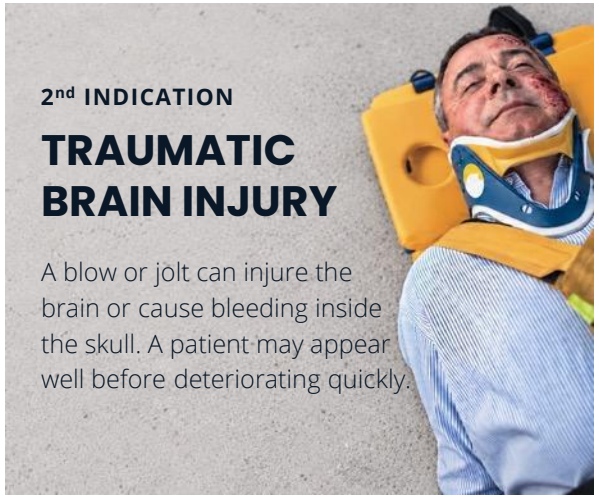
SCALE OF NEED

US$890bn

ANNUAL GLOBAL COST OF STROKE[1]

THIS COST IS PROJECTED TO **ALMOST DOUBLE** BY 2050[1]

(1) World Stroke Organization, Global Stroke Fact Sheet 2025, pp. 133–134.



2nd INDICATION

TRAUMATIC BRAIN INJURY

A blow or jolt can injure the brain or cause bleeding inside the skull. A patient may appear well before deteriorating quickly.

US$400bn

ANNUAL GLOBAL COST OF TBI[2]

30-40% OF HOSPITAL TBI CASES IN HIGH INCOME COUNTRIES ARE AGED 65+[2]

(2) Maas et al., The Lancet Neurology, 2022.

TARGET SETTINGS



Emergency Department



Bedside



Aeromedical



Ambulance



Aged care



Military



Sports



Worksites

Use case images are illustrative and subject to validation and regulatory authorisation.

Built with leaders in their field

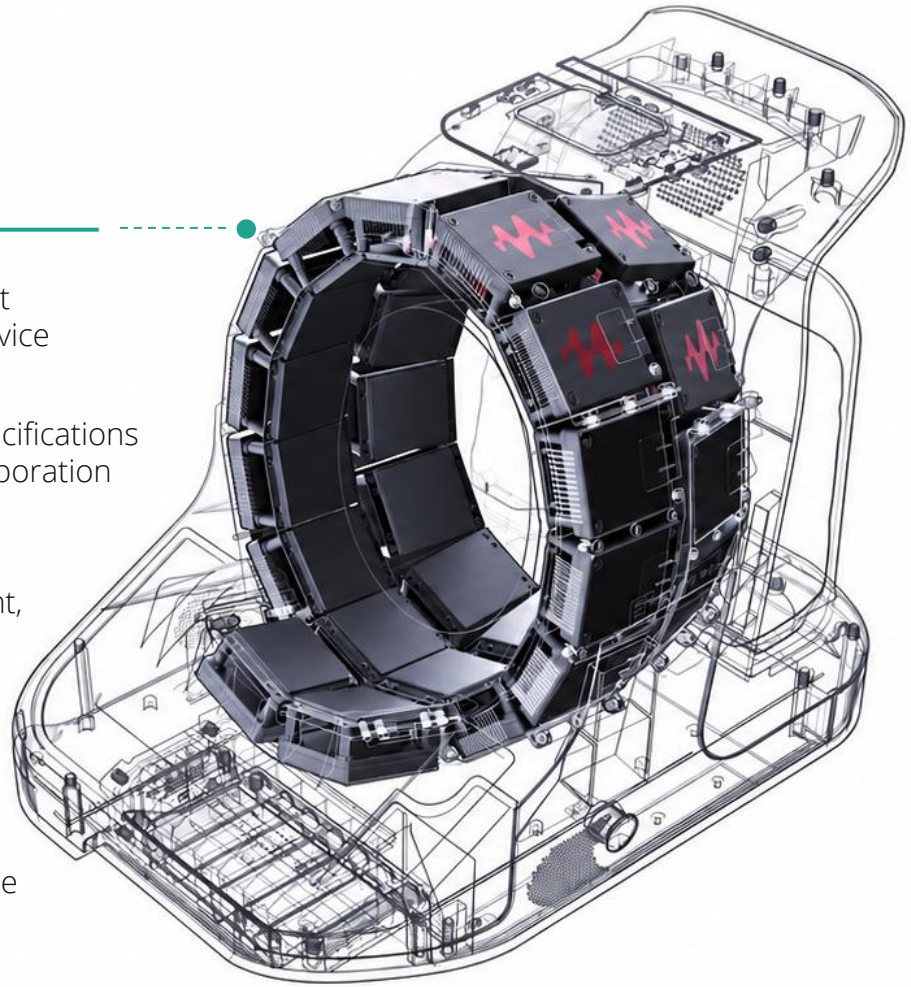
KEYSIGHT TECHNOLOGIES

DEVELOPMENT PARTNER

- **Invested A$17m in EMV** 8.8% shareholder
- **Global leader** in test and measurement solutions
- **NYSE:KEYS:** ~US$50bn market capitalisation

KEYSIGHT VNA

- Bespoke measurement engine inside every device
- Developed to EMV specifications over a multi-year collaboration and supply agreement
- Precision measurement, difficult to replicate



NVIDIA

AI AND COMPUTE SUPPORT

- EMV is an NVIDIA Inception member
- Proprietary simulation pipeline built on NVIDIA DGX

Australian Stroke Alliance

CLINICAL PARTNER

- National pre-hospital stroke program backed by $55m in federal funding
- Expert clinical guidance
- Access to non-dilutive funding
- Pre-hospital partners
- International network

Refer to ASX releases February 2024 ("Strategic A$15.28M Investment from Keysight") and September 2025 (placement) for details of Keysight's investment. Keysight market capitalisation as at 13 November 2026.



Why are we starting in stroke?

DEVASTATING GLOBAL BURDEN

1 in 4

adults will have a stroke in their lifetime[1]

2 in 3

survivors are left with permanent disability[2]

'TIME IS BRAIN'

1.9 million

brain cells lost every untreated minute[3]

3.6 years

Equivalent brain ageing per untreated hour[3]

DELAYS BEFORE TREATMENT

2 in 3

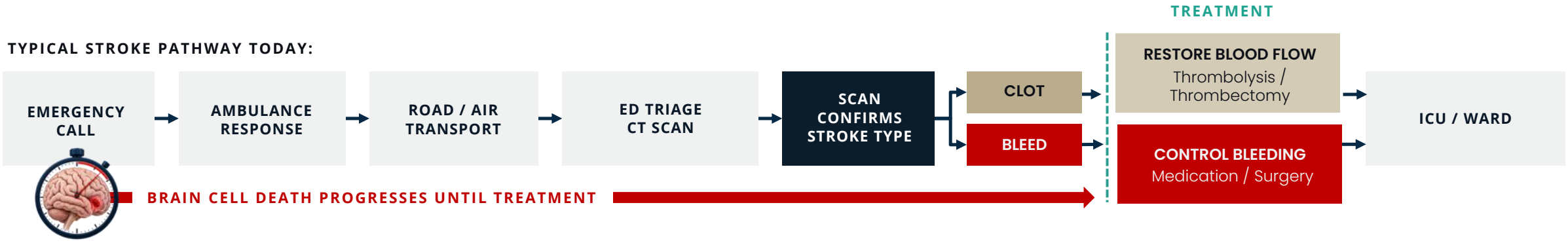
Patients treated more than three hours after onset[4]

90 mins

Average delay for transferred patients for clot removal (thrombectomy)[5]

(1) World Stroke Organization, Global Stroke Fact Sheet 2025
(2) Deloitte Access Economics, The Economic Impact of Stroke in Australia, 2013
(3) Saver JL, Time Is Brain-Quantified, Stroke, 2006
(4) Stroke Foundation, National Stroke Audit-Acute Services Report 2023
(5) Edwards et al., BMJ Neurology Open, 2020

Stroke can't be treated until subtype is confirmed



PRE-HOSPITAL

FIRST RESPONDER

The right treatment sooner.

- First responders can **differentiate suspected stroke type at the scene**
- **Guide transfer** and hospital bypass decisions
- Alert interventional teams **before arrival**
- Could enable earlier treatment decisions **at the scene**



HOSPITAL ARRIVAL

emu™

Faster triage and care.

- **Clot or bleed answered** on arrival
- **Fast track patients** to specialist care or transfer
- **Earlier answers** when CT access is delayed
- **Helps detect clot strokes** that basic CT can miss



IN-HOSPITAL STROKE DETECTION

emu™

Bedside detection.

- **Serial bedside scans** for at-risk inpatients
- **Positive detection triggers** immediate stroke response
- **Repeatable**, no transport, no ionising radiation
- **Scan sedated and post-operative patients**, where symptoms can be masked



Illustrative only. emu™ and First Responder are investigational devices, not available for sale and not intended to replace CT or MRI. Intended uses shown are subject to clinical trials and regulatory clearance.

Scanning in the field works but is currently not scalable

CT EQUIPPED AMBULANCES

Mobile Stroke Units deliver patient benefits

TREATED WITHIN THE 'GOLDEN HOUR'[1]

33% Mobile stroke unit vs **3%** Standard ambulance

MEDIAN TIME TO CLOT BUSTING TREATMENT[1]

72mins Mobile stroke unit vs **108mins** Standard ambulance



(1) Grotta et al., BEST-MSU trial, 2021

THE LIMITATIONS

Access remains limited & expensive

- Fewer than 50 MSU programs worldwide
- Heavy CT scanners = custom ambulances
- High setup costs of ~US$1m per unit[2]
- Annual running costs of ~US$1m[2]
- Specialist radiographers required
- Radiation shielding and compliance required

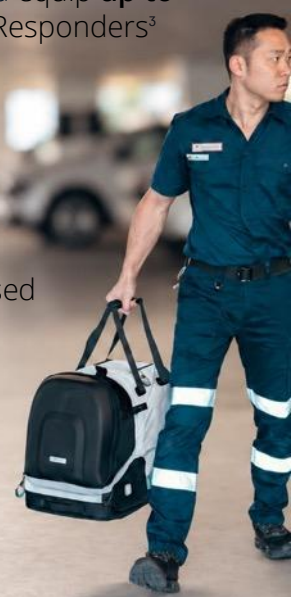


(2) Hiroki et al., 2025.

FIRST RESPONDER

Equip a fleet for the cost of 1 MSU

- 1st year cost of 1x MSU could equip **up to 40x ambulances** with First Responders[3]
- **Fits existing vehicles** with no customisation required
- **No specialist operators,** used by trained paramedics
- **No ionising radiation**, no shielding required



(3) Based on ~US$1m setup plus ~US$1m annual running costs per MSU (Hiroki et al., 2025) and a target First Responder capital price of US$50–100k per unit. Excludes First Responder servicing and consumables. Indicative only.

emu™ identifies stroke type with high accuracy in 'EMView'

✓ THE 'EMVIEW' MULTI-SITE STUDY · 307 PATIENTS · TESTED ON ~70 CASES

BLEED		CLOT	
92% SENSITIVITY	**85%** SPECIFICITY	**95%** SENSITIVITY	**80%** SPECIFICITY
66-98%	74-92%	75-99%	66-90%
95% Confidence Interval (CI)		95% Confidence Interval (CI)	

KEY OUTCOMES

- **Primary endpoint met.** Algorithm built and tested to classify stroke type
- **No device related adverse events.** Positive safety profile
- **Data peer reviewed.** npj Digital Medicine, a Nature Portfolio journal

nature research
npj | Digital Medicine

"Portable RF brain scanner enables stroke type detection using deep learning"
Khandan et al., 2026

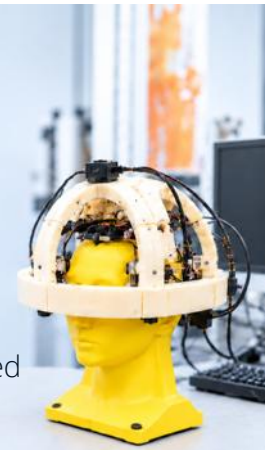
DESIGNED WITH CLINICIANS – INTERNATIONALLY AWARDED

reddot award
GOOD DESIGN AWARD® WINNER
iF
INTERNATIONAL DESIGN EXCELLENCE AWARDS

10+ YEARS R&D

University of Queensland

- Decade of foundational R&D
- Core RF sensing technology invented



8+ YEARS EMV DEVELOPMENT

First clinical prototype

- Proof of concept in patients
- Foundation for the emu™ design



TODAY

emu™ Pivotal (Validation) Trial advancing

- Enrolling across several leading stroke centres
- Pilot production line established in Sydney
- Upcoming FDA engagement
- Readout targeted **mid CY27**



EMView study results are from an unseen test set and are subject to confirmation in the ongoing pivotal trial. Refer to ASX releases "Algorithms Deliver Excellent Results In EMView Study" (November 2024) and "Enhanced Algorithm Performance From Continuous Innovation" (May 2025) for further details. Trial timelines are targets only.

emu™ integrates into busy emergency departments

EARLY CLINICAL EXPERIENCE PRESENTED BY MAYO CLINIC IN FLORIDA, A PARTICIPATING emu™ PIVOTAL TRIAL SITE



emu™ in an emergency department alcove in front of the CT suite, Mayo Clinic in Florida

"Compatible with emergency code stroke workflow"
Conclusion presented in the Mayo Clinic early emu™ experience presentation

Where the scan fits in a code stroke

Ambulance arrival → Stroke team assessment → CT imaging → Standard treatment

emu™ scan in under 10 minutes
during stroke team assessment or while waiting for CT

What Mayo Clinic presented

<10 min
per scan

~1 hour
operator training

No
device-related adverse events

Run by frontline staff
Operated by nurses and clinicians

Scan success
Achieved in the majority of cases

Easily deployed
Stationed in an alcove in front of the CT suite

Key challenges
Agitated patients due to their condition, staying still for the scan and a limited time window

Source: presentation by Y. Lee, Co-PI Dr D. Freeman and Dr L. Simon, "Portable Radiofrequency Brain Scanner Early Clinical Experience", 18th Annual Mayo Clinic Stroke and Cerebrovascular Disease Review, Amelia Island, Florida, October 2026 (©2026 Mayo Foundation for Medical Education and Research). For further details, refer to the Company's ASX release "Mayo Clinic emu Early Clinical Experience Presentation" dated 19 October 2026. Observations are as presented by one site in the ongoing emu™ pivotal trial. They describe workflow experience, not diagnostic performance, and may not be representative of other sites. emu™ is an investigational device and is not available for sale.

First Responder tested in the field

RFDS AEROMEDICAL STUDY | COMPLETE: MAY 2026

PROTOTYPE DEVICE

Scan quality unaffected by flight

- Data quality maintained across environments
- ~6-minute avg scan time

Feasibility in remote settings

- Deployed across 15 transfers
- 12 airstrips up to 371 km from Adelaide



MOBILE STROKE UNIT STUDY | STAGE 1 COMPLETE: SEPT 2026



PRODUCTION EQUIVALENT FIRST RESPONDER DEVICE

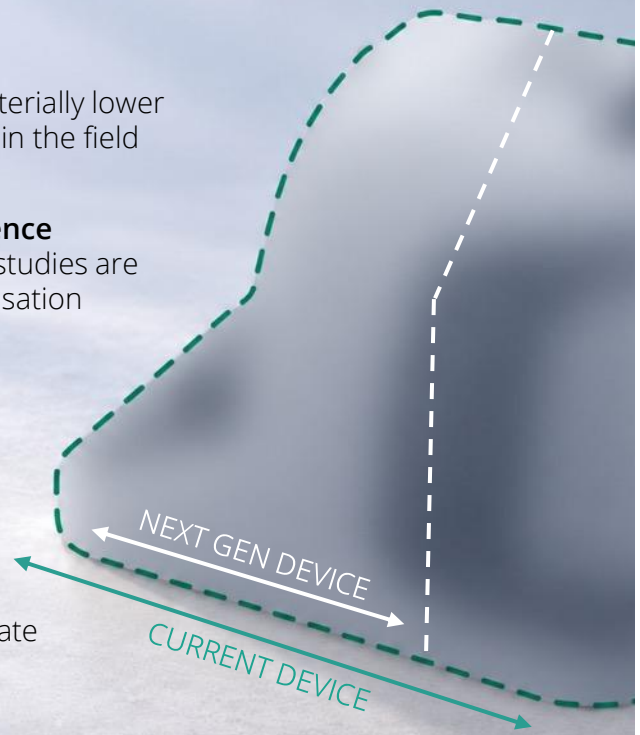
Next-gen First Responder device ready H1 CY27

Lighter, fewer components
A streamlined design with materially lower weight for easier deployment in the field

Shaped by frontline experience
Insights from RFDS and MSU studies are driving practical design optimisation

Built for maximum diagnostic capability
Simulations show materially higher signal-to-noise ratio

Planned regulatory path
emu™ intended as the predicate device, faster 510(k) pathway



Study results shown are from feasibility and usability studies of a prototype device. Refer to ASX releases dated 27 May 2026 (RFDS aeromedical study) and September 2026 (Mobile Stroke Unit Study Stage 1) for further details. Next-generation device timing is a target only.

Our Stroke & TBI clinical programs



emu™



First Responder

	Q4 CY26	Q1 CY27	Q2 CY27	Q3 CY27	Q4 CY27
Pivotal (Validation) Trial					
Current endpoint: bleeds Validate bleed detection		**Targeting full enrolment** Across bleed, clot and other		**Mid CY27** Data processing + analysis **readout**	**H2 CY27** FDA De Novo submission following readout
Added endpoint: clots Validate ischaemia detection using existing trial data	FDA engagement and protocol amendment for clot stroke detection				
Continuous Innovation Study					
190+ patients enrolled; ongoing data to refine algorithms and develop additional features	**Q4 CY26 – Q2 CY27** Growing training dataset for algorithms used on pivotal data				
Regional Benefits Study					
Faster regional stroke care; clinical and economic evidence for adoption and reimbursement		**Q1 CY27** Ethics submission		**H2 CY27** Study activated	
First Responder Development					
Production-equivalent devices Lighter units for clinical studies and regulatory testing		**First Responder Production Units** Finalised design and first builds			
Data Collection Study (Stroke & TBI) Paired with CT/MRI scans to train and test AI diagnostic models	**Q4 CY26 - Q1 CY27** Establish international clinical network			**Mid CY27** Start scans	
Mobile Stroke Unit: Stage 2 Collect paired hyperacute scans alongside CT				**H2 CY27** Commence with production units	
Standard Road Ambulance Study Deploy production units in standard road ambulances				**H2 CY27** Commence with production units	
Validation / Substantial Equivalence (Stroke & TBI) Diagnostic evidence for future FDA 510(k) using emu™ as predicate				**H2 CY27** Regulatory engagement on study design	

All timings are targets only and are subject to change, including as a result of patient recruitment rates, regulatory feedback, ethics approvals and funding. Planned regulatory pathways are subject to FDA agreement.

emu™ Pivotal Trial readout: a major inflection point

TRIAL DESIGN AND RECRUITMENT

Built for a clear result, with leading centres

CODE STROKE ALERT › BASELINE CT › emu™ SCAN

Eligible code stroke patients have a paired emu™ scan, typically shortly after baseline CT

TRIAL AT A GLANCE

- **300 patients for primary (bleed) endpoint:** 150 bleeds, 150 non-bleeds (clots, mimics)
- **Designed to support** FDA De Novo clearance
- **Blinded,** judged against ground truth diagnosis
- **Sites start** with training verification scans

RECRUITING SITES

United States:
Mayo Clinic, Mount Sinai, UCLA, Memorial Hermann, Prisma Health

Australia:
Royal Melbourne, Princess Alexandra, Liverpool



PRIMARY ENDPOINT

Bleed

- **>80% sensitivity and specificity**
  Correctly identify more than 4 in 5 bleeds and non-bleeds

ADDITIONAL ENDPOINT

Clot strokes (ischaemia)

- **Adding clot stroke detection** to the existing trial
- **Clot stroke patients are already enrolled,** with their scans available for analysis when the trial ends
- **Modest additions for the clot stroke endpoint,** to trial design and patient numbers, guided by upcoming FDA discussions. Bleed enrolment target unchanged
- **Saving up to two years** and millions of dollars versus a separate trial

WHERE THE BAR SITS TODAY

How emu™ compares with today's tools

	SENSITIVITY Real cases caught	SPECIFICITY False alarms avoided
NIHSS stroke scale, large clots	73–87%	52–74%
Standard CT, clot strokes in first 6 hours	66%	87%
Standard CT, bleeds	98%	99%
emu™ pivotal trial target, bleeds	**>80%**	**>80%**
emu™ pivotal trial target, clot strokes	*To be confirmed after FDA engagement*	
emu™ EMView study, bleeds	**92%**	**85%**
emu™ EMView study, clot strokes	**95%**	**80%**

For a De Novo grant, the FDA must find reasonable assurance of safety and effectiveness, with a device's probable benefits outweighing its probable risks for its intended use.

Sensitivity and specificity as reported in each source. Studies differ in patients and methods, so figures are indicative and not head-to-head. NIHSS: detection of large-vessel clots at thresholds of 6 to 10 or more, systematic review (Smith et al., Stroke 2018). CT clots: early infarction signs within 6 hours, systematic review (Wardlaw & Mielke, Radiology 2005). CT bleeds: modern CT within 6 hours for subarachnoid haemorrhage, meta-analysis (Dubosh et al., Stroke 2016); CT is the reference standard for bleeds, including in emu™ studies. emu™ EMView: unseen test set of 13 bleed/55 non-bleed and 20 clot/50 non-clot cases; see ASX releases of Nov 2024 and May 2025. Bleed target is the pivotal trial's primary objective; clot target to be confirmed after FDA engagement. emu™ is investigational.

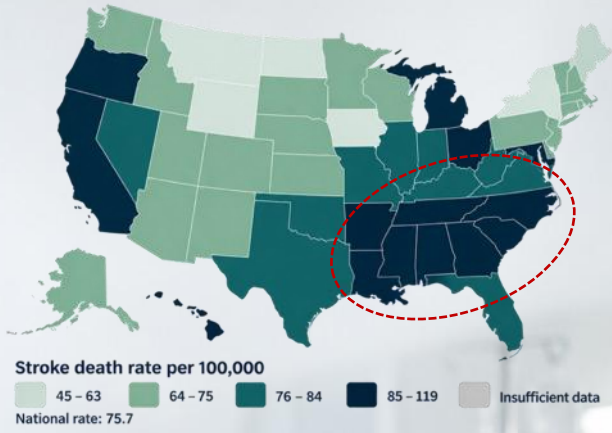
Initial commercialisation targets US ‘Stroke Belt’

OUR FIRST TARGET MARKET

The US ‘Stroke Belt’

800 HIGH-PRIORITY HOSPITALS

70	400	330
COMPREHENSIVE STROKE CENTRES	PRIMARY STROKE CENTRES	CRITICAL ACCESS HOSPITALS



WHY HERE FIRST?

- **Among the highest stroke death rates**, about 20% above the rest of the US
- **Long rural transfers** delay treatment; under-resourced rural settings represent an important unmet need addressed by the emu™
- **Limited advanced imaging**, no US state has MRI or high-end CT at every small rural hospital



HOW WE SELL INTO IT

Four pillars of evidence led adoption

- **Diagnostic accuracy,** measured in our pivotal trial using CT or MRI as the ground truth, designed to support FDA De Novo clearance
- **Clinical benefit,** through our Regional Benefits Study and potential reader studies[1] showing how emu™ scans inform clinical decisions
- **Hospital economic benefit,** with benefit study data and hospital cost modelling to show savings and revenue opportunities
- **Clinical champions,** trial investigators at leading stroke centres presenting and publishing their results

Delivered by a specialist direct sales force, with purchase or subscription pricing to suit each hospital

Supported by peer-to-peer advocacy, as clinical champions share their experience with peers

Launch plans are subject to FDA clearance. Hospital numbers are Company estimates of high-priority sites in the expanded Stroke Belt, based on stroke centre certification data from The Joint Commission (jointcommission.org) and critical access hospital data from Definitive Healthcare (“How many critical access hospitals are in the U.S.?”, November 2023, definitivehc.com). Stroke mortality: CDC NCHS Data Brief No. 207 (2015). Imaging: analysis of 1,060 critical access hospitals, which are rural hospitals with 25 beds or fewer (Khaliq et al., 2014). Reader study: independent clinicians review real patient cases with and without the emu™ scan, to measure how the scan changes their diagnosis or clinical decisions.

Commercial model drivers

EMVision revenue model

emu™



US$150–200k
Capital equipment

US$25
per scan (consumables)

~10%
of device price a year (servicing)

FIRST RESPONDER



US$50–100k
Capital equipment

US$50
per scan (consumables)

~10%
of device price a year (servicing)

Hospital economic benefit

ESTIMATED POTENTIAL ANNUAL BENEFIT OF ONE emu™
Australian public hospital, in A$, excluding the cost of the device

Reduction in transport costs	**A$120k**
More efficient CT and MRI use	**A$150k**
Better use of clot retrieval resources	**A$90k**
Reduction in length of stay	**A$78k**

A$438k
estimated annual benefit to one hospital

If these benefits are realised, the cost of an emu™ could be covered in its first year

Research and modelling conducted by Impact Health, August 2021

IMPACT HEALTH
ACCELERATING HEALTH INNOVATION

Reimbursement strategy

1 **Building the evidence**

The Regional Benefits Study, other benefit studies, modelling and potential reader studies (such as how scans inform clinical decisions) will provide clinical and economic evidence to support reimbursement and broad adoption across the portfolio.

2 **Temporary reimbursement**

Payment routes to support early adoption

emu™: Targeting New Technology APC (outpatient) and NTAP (inpatient) payments while usage data builds.

First Responder: Priced as routine capital equipment for EMS and hospital budgets. Seeking to build on Medicare telestroke codes for pre-hospital use.

3 **Permanent reimbursement**

Built-in payment to sustain long-term use

emu™: Critical access hospitals, about 40% of our Stroke Belt targets, are already paid by Medicare on a cost basis. Elsewhere, aiming for a standard outpatient payment (APC), with inpatient use supported by hospital savings and revenue opportunities.

First Responder: Rural hospital-run ambulances may also qualify for cost-based payment. Aiming for recognition in ambulance and outpatient rates.

Hospital economic benefit: The above numbers are based on an indicative model from a study undertaken in August 2021 and results may vary based on individual institutions and their use of the product. The savings estimated is from an Australian public hospital budget impact perspective and does not include post discharge patient outcomes related savings. Investors are cautioned that the estimated financial benefits may be affected by various factors outside of the control of the Company, such as cost inflation, costs and accessibility of substitute products, regulatory changes, implementation costs, availability of technical personnel, guideline changes, regulatory and policy factors and other changes. Reimbursement refers to US Medicare and applies only after FDA clearance and the assignment of billing codes. Critical access hospitals: small rural hospitals that Medicare pays at 101% of reasonable cost for its share of allowable costs, including equipment depreciation, outside the DRG and APC systems; about 330 of the Company's 800 high-priority Stroke Belt hospitals (Company estimate). NTAP: New Technology Add-on Payment (up to 65% of eligible technology cost for 2 to 3 years; excludes capital costs, so most relevant to per-scan or subscription pricing; requires evidence of substantial clinical improvement). APC: Ambulatory Payment Classification (hospital outpatient); a New Technology APC is a temporary category for a new service, used while Medicare gathers claims (usage and cost) data. Inpatient stays are paid by DRG (Diagnosis Related Group), a bundled payment with no separate device payment. Ambulance services are paid a bundled fee with no new-technology add-on, except that an ambulance service run by a critical access hospital is paid on a cost basis only where no other ambulance provider is within a 35-mile drive, which a small minority meet; telestroke consult codes pay the consulting clinician. Rate changes require CMS rule-making or legislation. Reimbursement outcomes are not guaranteed. Pricing is indicative. emu™ and First Responder are investigational and not available for sale.

Pilot production line in place for the US launch

PILOT PRODUCTION LINE AND R&D FACILITIES











INITIAL emu™ COMMERCIAL SUPPLY

~1 emu / week

ABOUT 50 DEVICES A YEAR
US$7.5–10M ANNUAL DEVICE REVENUE CAPACITY[1] - CURRENT LINE CAPACITY

Up to 3 / week

ABOUT 150 DEVICES A YEAR
US$22.5–30M ANNUAL DEVICE REVENUE CAPACITY[1] - WITH MODEST STAFF, STORAGE AND WAREHOUSING ADDITIONS

Ready for launch
Established to supply the planned US Stroke Belt launch

Quality in our hands
In-house assembly and testing

Scalable supply chain
Contract manufacturers for selected sub-components and consumables

Capital-light growth
Up to 3x output without a major facility expansion



Capacity figures are Company estimates; annual figures are the weekly rate over a full year. Illustrative only: line capacity multiplied by indicative emu™ pricing of US$150–200k per device. Not a forecast of sales or revenue. Excludes consumables and servicing. emu™ is an investigational device and is not available for sale. Commercial launch is subject to FDA clearance.

Scaling beyond the Stroke Belt

emu™

Scale across the US

Build from the Stroke Belt launch into hospital networks nationwide

Flexible route to market

Option to build out direct sales force or appoint a distributor as we scale

Expand internationally

Pursue European and Australian market access following US authorisation



ADDRESSABLE HOSPITAL SETTINGS

One emu each for ED, ICU and wards

Stroke Belt targets	800
Across the US	10,200
Priority International	19,400

First Responder

Progress towards clearance

Generate evidence for the planned 510(k) pathway, with emu™, once authorised, as the intended predicate

Strategic partnerships with emu™ hospitals

Work with emu™ hospitals to help commercialise First Responder, including those with their own EMS ambulance fleets

Enter road and air fleets

Extend adoption from hospital partners into wider road and air ambulance networks

ROAD AND AIR AMBULANCES

Stroke Belt targets	6,580
Across the US	60,000
Priority International	71,500

GROWTH BEYOND THE INITIAL SALE

Hardware upgrade path | First Responder's next-generation hardware could be cart-mounted as a future emu™ upgrade, once cleared

Paid software upgrades | New indications such as TBI, and new features, sold as upgrades to existing customers once cleared

Company estimates of addressable units. Hospital settings are departments that could each hold an emu™ (emergency department, intensive care unit, and stroke and other wards), so one hospital can have several. Both charts are drawn to the same scale. emu™ and First Responder are investigational and not available for sale. Statements about future plans are forward-looking and subject to regulatory clearance.

The unmet need in point-of-care TBI diagnosis

THE SCALE

A neglected public health challenge

- 'Pervasive and neglected': The Lancet Neurology Commission on TBI[1]
- 50-60 million TBIs each year, costing ~US$400 billion annually [1]
- Bleeds can be clinically silent: patients may be alert while a bleed expands

THE ACCESS GAP

Far from CT: diagnosis is delayed

- Identifying a bleed early is the critical decision in TBI
- Early identification of lesions can trigger admission or life-saving surgery
- Outside major hospitals, patients can wait hours for CT; some sites have none

THE EFFICIENCY GAP

Near CT: most scans are clear

- CT decision-making is inefficient: ~90% of scans show no intracranial injury[3]
- Those patients are exposed to radiation for no diagnostic benefit
- ~2.8m US TBI-related ED visits, admissions and deaths a year[2]

WITH EMVISION | BLEED DETECTION AT FIRST CONTACT | BUILDS DIRECTLY ON OUR MODE OF OPERATION IN HAEMORRHAGIC STROKE DETECTION

1 Scan at first contact
A paramedic, aged care nurse or clinician scans the patient where they are, in minutes

2 Bleed identified or not
Result brings treatment and transfer decisions forward; no bleed means no unnecessary trip

3 Hospital ready on arrival
Results arrive first; CT, neurosurgery or ICU mobilised as needed, cutting time to treatment

Sources: [1] Maas AIR et al. Lancet Neurology Commission on TBI. Lancet Neurol 2017;16:987-1048. [2] Taylor CA et al. TBI-related ED visits, hospitalizations and deaths, United States 2007 and 2013. MMWR Surveill Summ 2017;66(9):1-16 (CDC): approx. 2.8 million in 2013. [3] Haydel MJ et al. N Engl J Med 2000;343:100-5 (6.9% positive CT); Stiell IG et al. Lancet 2001;357:1391-6 (8% clinically important injury). TBI is a planned indication. EMVision's devices have not yet been validated for TBI, and the pathway shown illustrates intended use only.

TBI expands our commercial opportunity

TBI CAN MORE THAN DOUBLE EMV'S CONSUMABLES OPPORTUNITY

TBI incidence drives recurring per-scan consumables revenue

Stroke

>12 million
Cases of stroke globally per annum[1]

~800,000
US strokes per annum[1]

TBI

>50 million
Cases of TBI globally per annum[2]

~2.8 million
US TBI-related ED visits, admissions and deaths per annum[3]

>3.5m time-critical brain emergencies
in the US each year[1,3]

Scan volume x consumable price per scan
= Annual Recurring Revenue

NEW MARKETS



MILITARY & DEFENCE

>500,000

first-time TBI diagnoses among US service members since 2000[4]. Need remains for a non-invasive, objective haemorrhage detection device usable in far-forward conditions



AGED CARE

~4x

higher fall-related TBI hospitalisation rate for aged-care residents than community-dwelling over-65s (NSW)[5]. About one in three people over 65 falls at least once a year[6]

Sources: [1] Martin SS et al. 2025 Heart Disease and Stroke Statistics, American Heart Association. Circulation 2025;151(8):e41-e660: approx. 795,000 strokes per year in the US. Global stroke: World Stroke Organization Global Stroke Fact Sheet 2022 (approx. 12 million new strokes per year). [2] Maas AIR et al. Lancet Neurol 2017;16:987-1048. [3] Taylor CA et al. MMWR Surveill Summ 2017;66(9):1-16 (CDC): approx. 2.8 million TBI-related ED visits, hospitalisations and deaths in 2013. [4] US DoD Traumatic Brain Injury Center of Excellence, DOD TBI Worldwide Numbers: 535,544 diagnoses, 2000 to Q4 2025. [5] Harvey LA et al. Australas J Ageing 2017;36(2):144-150: rate ratio 3.7 (95% CI 3.4-4.1). [6] WHO Step Safely (2021). 'More than doubles' is a Company estimate based on relative annual incidence of TBI and stroke under the planned per-scan consumable model, not a forecast. TBI is a planned indication, subject to clinical studies and regulatory clearance.

Grant backed development & validation

AUSTRALIAN STROKE ALLIANCE MoU

MoU with the Australian Stroke Alliance

- **Non-binding MoU:** working together to secure non-dilutive funding to transform pre-hospital stroke diagnosis
- **Builds on:** the $40m MRFF "golden hour" program, which has provided $8m in non-dilutive funding to EMVision
- **Focus:** pursuing comparable continuation funding via the MRFF and other competitive grants

ADVANTAGES OF GRANTS

- Non-dilutive capital
- Funds clinical evidence
- Opens partnerships and networks
- Independent validation via competitive selection

$27M IN GRANT FUNDING AWARDED SINCE INCEPTION | $3.7M REMAINING



Grants awarded since 2017. Received and remaining amounts are as at 30 September 2026. Remaining grant receipts are subject to milestones and satisfactory progress reporting. The MoU with Australian Stroke Alliance Ltd is non-binding and there is no guarantee that further funding will be secured. MRFF: Medical Research Future Fund. 2017 CRC-P of $3.5m includes partner contributions. Refer to the Company's Appendix 4C reports and ASX releases for more information.

Why EMVision

WHY NOW

Company defining milestones in 2027

EMVision stands at an important inflection point as it transitions from research and development towards commercialisation and market launch

TODAY
Four major milestones ahead

EARLY TO MID CY27
First Responder production equivalent unit builds

MID CY27
emu™ pivotal trial readout

H2 CY27
FDA De Novo submission

H2 CY27
Next-gen First Responder studies



WHY EMVISION

Targeting large global health burdens
Over 12 million new strokes a year worldwide; stroke is the second leading cause of death.

A value proposition we have not seen replicated
One portable, non-ionising platform for the bedside and the ambulance, run by frontline staff.

Driven by clinical demand and unmet need
Designed with clinicians and trialled at leading US and Australian stroke centres.

Encouraging early results, pivotal data in sight
EMView study of 307 participants published; pivotal trial readout planned for mid CY27.

Second-generation ultra lightweight First Responder advancing
Previous First Responder prototype successfully tested in road and air feasibility studies.

Expansion into traumatic brain injury
Second planned indication for the same platform, growing the addressable and consumables market.

Backed by leading partners and collaborators
Including strategic investor Keysight Technologies and the Australian Stroke Alliance.

Commercial foundations being laid ahead of market entry
Pilot production line, a US Stroke Belt launch plan and A$18.1m cash at 30 September 2026.

Milestone timing is indicative and may change. Trial results and regulatory outcomes are not yet known and are not guaranteed. emu™ and First Responder are investigational and not available for sale. Nothing on this slide is financial product advice. Stroke figures: World Stroke Organization Global Stroke Fact Sheet 2025.

Experienced healthcare leadership

BOARD OF DIRECTORS



John Keep
Independent Non-Executive Chairman
As former CEO of Queensland Diagnostic Imaging, John grew the business to become one of the state's leading private imaging groups and led the successful trade sale of the group



Dr Philip Dubois
Independent Non-Executive Director
Neuroradiologist, former CEO of Sonic Healthcare Imaging (ASX:SHL), $10bn market cap. Former A/Prof. of Radiology at the University of Queensland Medical School. Has served on numerous government and radiology professional bodies.



Tony Keane
Independent Non-Executive Director
Former Chairman of National Storage REIT, which he chaired through its A$4bn acquisition by Brookfield and GIC in 2026. Previously held numerous roles with a major trading bank, principally in business, corporate and institutional banking.



Carmel Monaghan
Independent Non-Executive Director
Ms Monaghan is an accomplished healthcare leader, being the former CEO of Ramsay Health Care Australia (ASX:RHC). Ms Monaghan worked across hospital, corporate and global positions at Ramsay for almost three decades. Non-Executive Director of Regis Healthcare (ASX:REG).



Patryk Kania
Independent Non-Executive Director
Medical device executive with over 20 years commercialisation experience across the US, Europe and APAC, within sales, marketing and general management. Current CEO of Field Orthopaedics, previously held senior roles at Abbott, J&J and Roche.



Emma Waldon
Company Secretary
Over 20 years corporate advisory, capital market and corporate governance experience in Australia and the UK.

LEADERSHIP TEAM



Scott Kirkland
Chief Executive Officer, Managing Director, Co-Founder
Sales and marketing executive, former Head of Client Sales at US-venture backed global AI advertising company, Quantcast.



Forough Khandan
Chief Technology Officer
Over 15 years medical device development expertise. Former Head of Program Management at Nanosonics (ASX:NAN), a >$1bn medical device success story.



Prof. Stuart Crozier
Chief Scientific Adviser
Co-inventor and pioneer in medical imaging innovation. Prof. Crozier's technologies are now central to 65% of all MRI machines.



Karl Pechmann
Chief Financial Officer
Chartered Accountant and seasoned senior executive across several ASX-listed medical technology and life science companies.



Christian Wight PhD
Head of Regulatory and Clinical Affairs
Previously Regulatory Manager at Corin. Multiple successful FDA, CE and TGA registrations



A/Prof. Konstanty Bialkowski
Head of Technology Development
Co-inventor and expert in near-field radar systems, multiple element antenna systems and wireless communications.



Adam Millhouse
Head of Corporate Strategy & Development
Over 19 years capital market experience, ex-Macquarie Group, ex-Marble Bar Asset Management.



Zili Xu PhD
AI/ML Team Lead
Specialises in AI and machine learning, with extensive experience developing advanced sensing technologies across medical devices, autonomous vehicles (LiDAR), radar, satellite navigation and metal detection.

Thank you

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“It cannot be underestimated how important this cutting-edge technology could become for future stroke management.”

Professor Geoffrey Donnan AO
Stroke Neurologist
Co-chair ASA, Past-President of World Stroke Organization

