24/11/2026

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ASX Release

AGM CHAIR'S ADDRESS & MANAGING DIRECTOR PRESENTATION

EMVision Medical Devices Limited (ASX:EMV) ("EMVision" or the "Company") is pleased to provide copies of the Chair's Address and Managing Director Presentation to be given at its Annual General Meeting held at 2.00PM (AEDT) on 24 November 2026.

Chair's Address – John Keep

Before we turn to the formal business, I want to begin with a thank you. To our shareholders, thank you for joining us on the journey so far.

Bringing a new medical technology to market takes time, patience and conviction, and we do not take your support for granted.

This has been another year of excellent progress. Our pivotal trial of emu™ now spans ten hospitals across Australia and the United States, with strong engagement from some of the world's leading academic medical centres. First Responder, our next generation device building on emu, continues to earn international recognition, and the production-equivalent units now being built are a dramatic step forward.

The First Responder has also attracted additional non-dilutive funding, with a recent $3.0 million Cooperative Research Centres Projects grant to help us extend the technology to traumatic brain injury. Scott will take you through the detail shortly.

I am delighted to say that the milestones that unlock commercialisation are now firmly in sight. This time next year, I hope to be able to report to you that our pivotal trial has been successful, our submission has been lodged with the FDA awaiting its decision. Everything we have built so far has been to get us to that point, and from there to bring the emu™, and then First Responder, to market.

On behalf of the Board, thank you to Scott and the team, to our clinical collaborators, and to the patients and families who take part in our studies.

[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 (haemorrhagic 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.

About Traumatic Brain Injury

Traumatic brain injury (TBI) occurs when an external force, such as a fall, road accident, sporting collision or blast, injures the brain. It ranges from mild (concussion) to moderate and severe, and is a leading cause of death and disability worldwide. Its most time-critical complication is bleeding inside the skull (intracranial haemorrhage), which can expand rapidly and may require urgent neurosurgical intervention. Because the signs of a bleed can be subtle or delayed, suspected head injuries are routinely sent to hospital for a CT scan, the great majority of which show no bleed. Falls are the leading cause of TBI, particularly in older people, for whom the use of blood-thinning medication increases the risk of a bleed. EMVision is working to extend its point-of-care brain scanning technology to the detection of traumatic intracranial haemorrhage, wherever the injury occurs.

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.

CEO PRESENTATION AGM

NOVEMBER 2026

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 $6.7m in active grants Cash as at 30 September, grants as at November 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

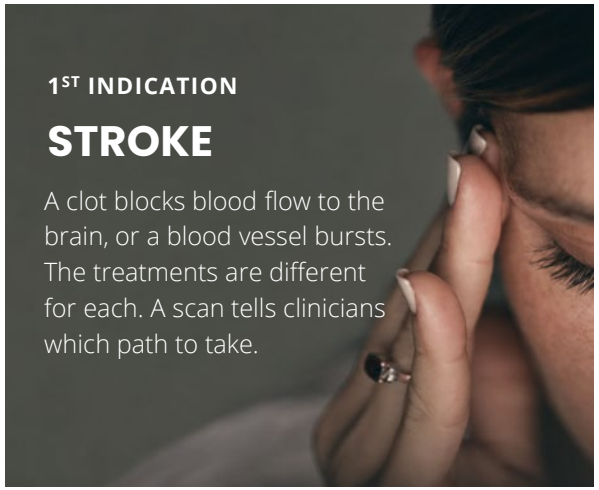


Provide rapid and reliable insights at the point of care to accelerate clinical decision making and reduce time to treatment

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.

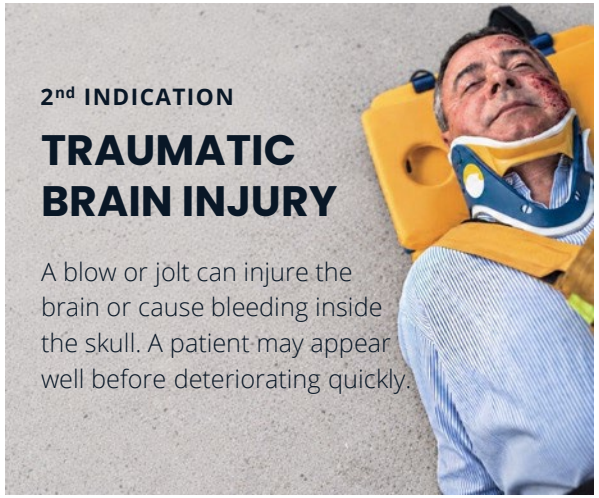
SCALE OF NEED

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



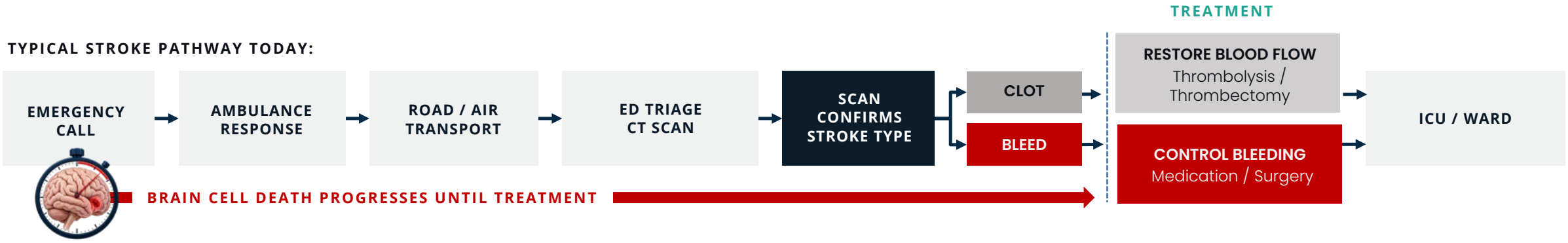
Sports



Worksites

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

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

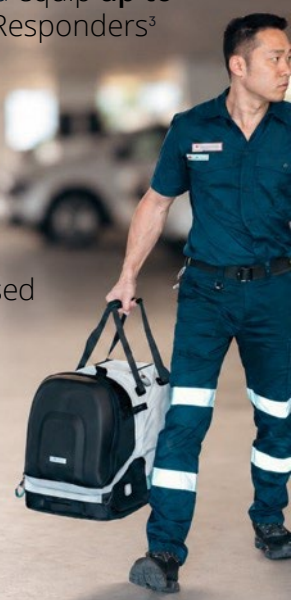


(2) Hiroki et al., 2025.

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.

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

PROTOTYPE DEVICE

Rapid scanning at the scene

- Patients enrolled in real-world settings
- ~6-minute avg scan time

Easy to operate

- Rated easy to use by all operators
- No device related adverse events



PRODUCTION EQUIVALENT FIRST RESPONDER DEVICE

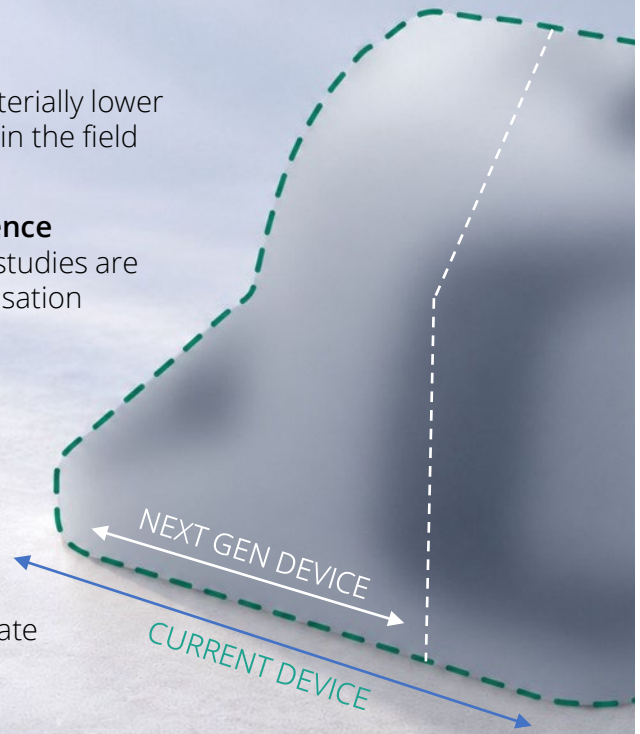
Next-gen First Responder device ready H1 CY27

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.

Built with leaders in their field

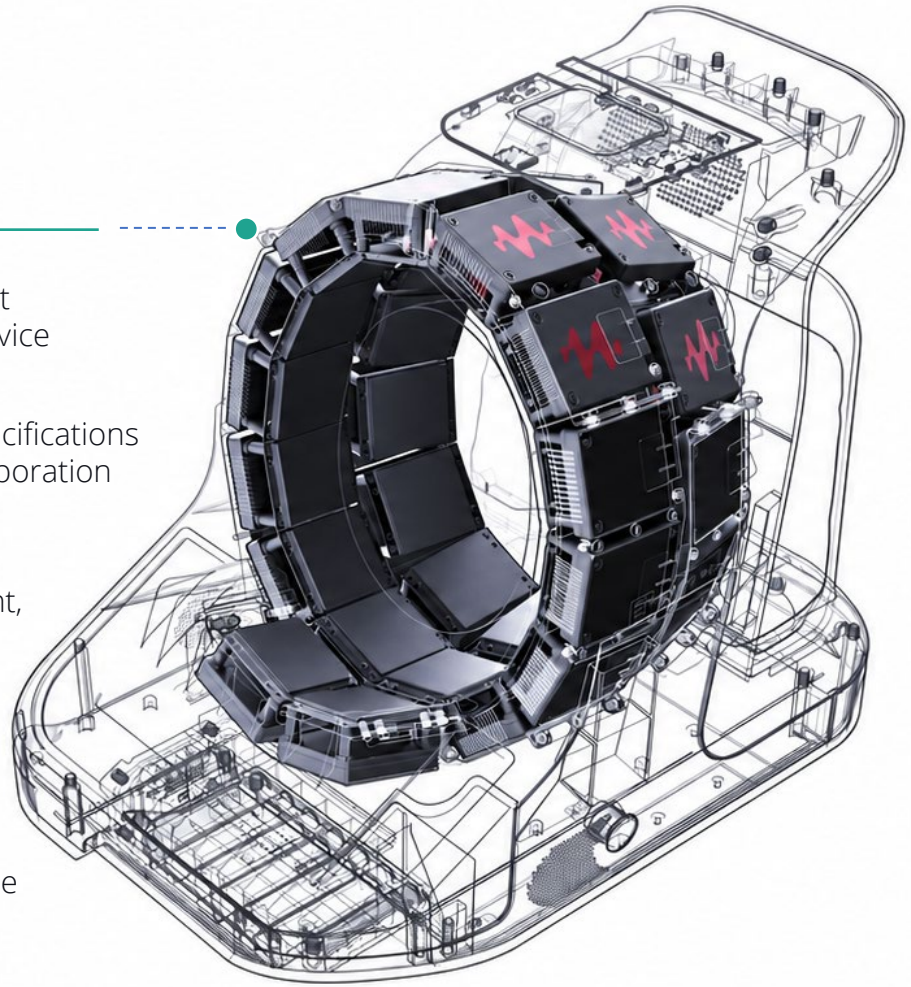
KEYSIGHT TECHNOLOGIES

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.

New $3m Non-Dilutive CRC-P award unlocks TBI



THE SOLUTION

First Responder, built for the point of care

- **Ultra-lightweight, non-ionising** brain scanner carried to the patient
- Battery powered for **road and air ambulance** deployment at the scene
- **AI-based bleed detection** in minutes, building on our stroke algorithms



THE CRC-P PROJECT

$3m grant to adapt our technology for TBI

- **Primary:** develop and validate algorithm to detect traumatic brain bleeds
- **Secondary:** explore whether dielectric changes can aid concussion assessment
- **Outcome:** inform earlier treatment and transfer decisions, optimise CT triage, reduce unnecessary exposure to radiation



WHAT COMES NEXT

The path to preliminary diagnostic performance

- Execute Commonwealth Funding Agreement and Partner Agreements; commence **Q1 CY27**
- Metro North Health and Titan Prehospital Innovation partners; first scans **H2 CY27**
- **Preliminary sensitivity and specificity**, validated against hospital CT as the reference standard, to underpin the path to market for TBI

Matched funding program (cash and/or in-kind). Funding subject to Commonwealth and partner agreements. EMVision's third CRC-P award. New grant, separate from the $3m CRC-P grant awarded in 2025 for the emu™ Regional Benefits Study.

One device, two time critical indications: more use, more buyers

TBI INDICATION EXPECTED TO 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, each one a decision that could be made at first contact[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].

Timing indicative; subject to execution of agreements

THE PATH TO A TBI INDICATION

NOV 2026	COMING MONTHS	H1 CY27	H2 CY27	STUDY RECRUITMENT & COMPLETION	BEYOND THE CRC-P
1	2	3	4	5	6
Grant awarded	Agreements executed	Protocol and ethics	Study activation	Preliminary performance	TBI regulatory study & market clearance

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.

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					
200+ 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: screening and enrolment process

THE PATIENT PATHWAY AT A PARTICIPATING SITE



1 Code stroke

Suspected stroke patient arrives and the stroke team is called

2 Baseline CT

Bleeds detected by Non-contrast CT; Ischaemia often requiring CT perfusion or MRI

3 Screening

Adult with symptoms of a suspected stroke, within 24 hours of onset

4 emu™ scan

Paired bedside scan, shortly after CT

5 Enrolled

Patient or family gives written consent, sometimes days later

BUILT FOR EFFICIENT RECRUITMENT

<10 min

per emu™ scan, by staff after ~1 hour of training

Deferred consent

Ethics approved as minimal risk study for streamlined consent

Broad eligibility

Adult with a suspected stroke within 24 hours prior to treatment

Extended hours

After hours coverage at sites means more patients screened and enrolled

After CT research teams know who has a haemorrhage, so they can be selectively recruited to conclude the haemorrhage study arm

RECRUITMENT CONSIDERATIONS

- **Patient care comes first:** many patients are critically unwell, so teams prioritise stabilising and treating them so not every patient can be scanned.
- **A narrow window:** scanning has to occur within 24 hours of symptom onset and within 60 mins of baseline imaging.
- **Consent to retain data:** consent must be obtained, before or after the scan, or the data cannot be kept.
- **Not every patient is suitable:** head size, metal implants or treatment already started can rule a patient out.
- **Site resourcing:** research staff at sites can change, so our US based trainers can rapidly train new operators as required.

Scan time and training as presented by Mayo Clinic in Florida, one participating site, October 2026. emu™ is an investigational device not yet regulatory approved for clinical use in any global region.

emu™ Pivotal Trial: enrolment, sites and conduct

ENROLMENT PROGRESS

More capacity recruiting into primary analysis

Driven by more sites, expanded hours and training verification complete at current sites

TRAINING VERIFICATION

~85 patients

Ensures high quality scans and high quality study execution from sites

PRIMARY ANALYSIS

~170 of 300

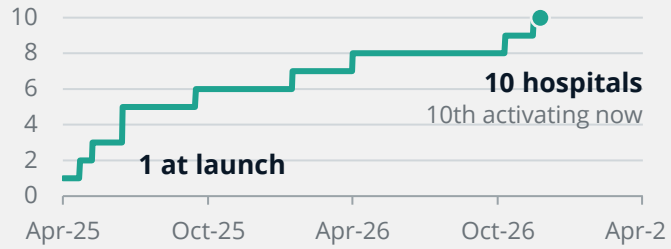
Nearly every new recruit goes here
Datasets for processing for primary endpoint

Haemorrhage arm: 150 target

Non-haemorrhage arm: 150 target

HOSPITALS RECRUITING OVER TIME

From 1 site at launch to 10 today



Enrolment figures as at early November 2026

LEADING STROKE CENTRES

Ten centres across the US and Australia

UNITED STATES (7)

Mayo Clinic Jacksonville, FL
Mt Sinai Hospital, NY
Mt Sinai West, NY
Ronald Reagan UCLA Med. Center, CA
Memorial Hermann – TMC, TX
Memorial Hermann – Memorial City, TX
Prisma Health, SC (recently initiated)
+ additional leading centres in activation

AUSTRALIA (3)

Royal Melbourne Hospital, VIC
Liverpool Hospital, NSW
Princess Alexandra Hospital, QLD

INDEPENDENT AND RIGOROUS

Blinded study, built for a clear and credible result

Primary endpoint: bleed or not, sensitivity and specificity >80%, statistically significant. Planned ischaemia endpoint to be confirmed following FDA feedback.

Independently run: CRO managed at arm's length, with periodic summary updates.

Expert confirmed: independent expert panel will confirm each final diagnosis (haemorrhage, ischaemia, mimic or other) to determine 'ground truth'. Live breakdowns are not reported.

Expected sequence: as per protocol, all suspected strokes are recruited. The non-haemorrhage arm fills first because those cases are more common.

Next phase: as the protocol provides, sites then target haemorrhage patients, alongside ischaemic patients for the planned ischaemia (clot stroke) detection endpoint.

Added ischaemia endpoint: ischaemic patients are already enrolled, so ischaemia can be validated in this trial, subject to FDA feedback. Despite a modest expected sample increase, given the higher prevalence of ischaemia, we do not expect a material impact on timelines

How continuous innovation helps de-risk the Pivotal Trial

FROM TRAINING DATA TO FINAL ANALYSIS

TRAINING DATA

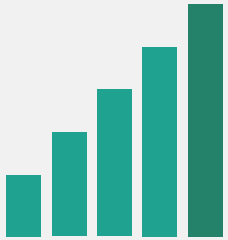
Continuous Innovation Study: >200 patients scanned outside the trial

Additional training data: from other studies

DURING RECRUITMENT

Algorithms keep improving

Retrained and extended as training data grows



AT COMPLETION

Algorithms locked

Each frozen before blinded data is processed

FINAL ANALYSIS

One analysis per endpoint

Run once: each locked algorithm processes the primary analysis scans for its endpoint.

Independently checked: against the expert panel's diagnosis.

Measured against target: sensitivity and specificity objectives.

BLINDING FIREWALL

Pivotal primary analysis scans: collected at trial sites and kept blinded

Held blinded

No processing of primary analysis scans while recruitment continues

Enrolment complete

HOW THIS DE-RISKS THE READOUT

Most advanced algorithm: the version tested is the latest, trained on the largest dataset available.

Independent test: training data is kept separate from the blinded primary analysis scans.

Time works in our favour: each month of recruitment adds training data before the algorithm is locked.

Continuous Innovation Study: more than 200 patients recruited to date at John Hunter, Box Hill and Princess Alexandra hospitals. Royal Adelaide Hospital and The Alfred are being activated to further increase EMVision's proprietary datasets.

Forward-looking statements: algorithm performance and trial results are not guaranteed.

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.

Ischaemia addition: clinical and regulatory roadmap

REGULATORY ENGAGEMENT: FDA

SUBMIT: Q4 CY26

Pre-submission to be lodged with the FDA

Includes ischaemia endpoint addition: align on ischaemia endpoint expansion, including sampling, clinical claims and performance thresholds, as drawn from risk/benefit analysis under the intended use.

RESPONSE: Q1 CY27

FDA feedback

Protocol amendment informed by FDA consultation

Trial readout supports De Novo submission

H2 CY27

FDA De Novo submission

Regulatory submission: market authorisation application for the USA is filed with the FDA, with global markets to follow.

CLINICAL STUDY: emu™ PIVOTAL TRIAL

CURRENT: IN PROGRESS

Continued trial enrolment

Ongoing recruitment at activated sites: enrolment continues per the existing protocol, including haemorrhagic stroke, ischaemic stroke and mimic.

Q1 CY27

Protocol amendment

Addition of ischaemia objective: a modest sample increase, to be enrolled on existing timelines given the higher prevalence of ischaemic stroke.

MID CY27

Trial readout

Primary endpoint analysis: after the final patient is enrolled, data lock and analysis are completed, including final readout.

H2 CY27

Go to market preparation

Commercial readiness: launch plans, sales, marketing and customer support infrastructure is established leading into FDA approval.

Indicative milestones. Timing, and whether the haemorrhage and planned ischaemia endpoints are analysed together or sequentially, is subject to study progress and FDA feedback.

Growing international engagement and recognition in 2026

STROKE CONFERENCES



Mayo Clinic Stroke Review, USA: early emu™ code stroke experience (Oct).

World Stroke Congress, South Korea: emu™ Pivotal Trial poster (Oct).

ANZSOC, Australia: three presentations across emu™ and First Responder (Aug).

International Stroke Conference, USA: rural stroke diagnosis poster (Feb).

RACE Research Week, Australia: emu™ for remote hospitals without CT (Sep).

PREHOSPITAL AND DEFENCE



Aeromed Conference, Australia: prehospital feasibility trial outcomes (Oct).

MHSRS, USA: poster on brain injury detection for triage and evacuation in suspected TBI (Aug).

NABI-Con, USA: radiofrequency scanning and machine learning for portable neurodiagnostics (Apr).

Defence Human Sciences Symposium, Australia: poster on decision-making at the point of injury (Nov).

TECHNOLOGY SHOWCASES

CAA Congress: Council of Ambulance Authorities, Canberra (Aug).

ANZ Stroke Organisation Conference: Brisbane (Aug).

National Rural Health Conference: Adelaide (Sep).

NSW Parliament MedTech Showcase: inaugural event, Sydney (Aug).

MTAA MedTech Innovation Showcase: Canberra (Jun).

Int. Conference on Emergency Medicine: Germany (Jun).

AWARDS AND PUBLICATIONS

BID26 Grand Prize: First Responder, Ibero-American Design Biennial (Nov).

iF Design Award 2026: First Responder.

AFR Most Innovative Companies 2026

npj Digital Medicine: 'EMView' study (Jul).

Powerful peer-to-peer advocacy: clinical collaborators presenting their own experience with emu™ and First Responder to their peers

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.

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 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

