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## ASX Release

### EMVISION GO-TO-MARKET STRATEGY AND E&P HEALTHCARE CONFERENCE PRESENTATION

**EMVision Medical Devices Limited (ASX:EMV)** (“EMVision” or the “Company”) is pleased to provide shareholders and the market generally with the attached presentation that will be given by EMVision’s CEO and Co-Founder Scott Kirkland at the E&P Small Cap Healthcare Conference and at the Company’s Go-To-Market Strategy Webinar on 9 September 2025.

Authorised for release by the Board of the Company.

#### [ENDS]

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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](http://www.emvisionmedical.com)

## **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 (ASX:EMV) GO-TO-MARKET PRESENTATION

SEPTEMBER 2025



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# INTRODUCTION TO EMVISION

*Our mission is to reduce the global burden of stroke and traumatic brain injury through the deployment of two world-first portable brain scanning devices targeting unmet clinical needs*

<b>Novel technology</b>	Over 15 years and > \$50m invested in groundbreaking research and development in novel radio frequency sensing and imaging technology, originating from the University of Queensland.
<b>Differentiated solution</b>	Portable devices provide rapid neurodiagnostic capabilities across diverse settings, facilitating timely triage, transfer or treatment decisions.
<b>Large market opportunities</b>	Multi-billion dollar opportunity in stroke care alone and a second planned indication in traumatic brain injury.
<b>Encouraging clinical data</b>	300-patient pre-validation trial met primary endpoints, providing confidence to proceed with pivotal trial to support FDA clearance (in progress).
<b>Partners &amp; key opinion leader support</b>	Executed several leading clinical and industry collaborations, including strategic investment from Keysight Technologies and commercial partner of the Australian Stroke Alliance.
<b>Experienced leadership</b>	Aligned, high quality board and management team, with extensive experience across medical device innovation, commercialisation and healthcare systems.

emu™ (in-hospital)



First Responder (pre-hospital)



# MEET THE TEAM

*Significant medical device development and global commercialisation expertise*

## Executive Leadership Team



**Scott Kirkland**

**CEO, Managing Director, Co-founder**

Sales and marketing executive, former Head of Client Sales at US-venture backed global AI advertising company Quantcast.



**Prof. Stuart Crozier**

**Chief Scientific Officer, Co-inventor**

Pioneer in medical imaging innovation. Prof. Crozier's technologies are now central to 65% of all MRI machines.



**Dr Christian Wight**

**Head of Regulatory, Quality & ClinOps**

Previously Regulatory Manager at Corin. Multiple successful FDA, CE and TGA registrations



**Forough Khandan**

**Chief Technology Officer**

Over 15 years medical device development expertise. Former Head of Program Management Nanosonics (ASX:NAN), a >\$1bn medical device success story.



**Robert Tiller**

**Head of Design**

Over 25 years in medical device product design and commercialisation, previously CEO of Tiller Design.



**Adam Millhouse**

**Head of Corporate Development & Strategy**

Over 18 years capital market experience, ex-Macquarie Group, ex-Marble Bar Asset Management.

## 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 group 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), >\$11bn market cap. Currently an A/Prof. of Radiology at the University of Queensland Medical School. Has served on numerous government and radiology group bodies.



**Tony Keane**

**Independent Non-Executive Director**

Non-executive Chairman of National Storage Holdings Ltd (ASX:NSR), >\$3bn market cap. 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 Healthcare Australia (ASX:RHC). Ms Monaghan worked across hospital, corporate and global positions at Ramsay for almost three decades.



**Patryk Kania**

**Independent Non-Executive Director**

Medical device executive with over 20 years commercialisation experience across 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 UK.

# WHY ARE WE STARTING IN STROKE?

*Stroke remains a leading cause of mortality and disability globally*

Stroke Statistics	2021 (Actual)	2050 (Estimate)	Δ
Stroke incidence	12 million	21 million	+80%
Deaths from stroke	7 million	10 million	+40%
Disability adjusted life years lost	145 million	189 million	+30%
Annual cost	US\$891 billion	US\$1.6 trillion	+80%



1 in 4 adults will suffer from a stroke in their lifetime.



Around two-thirds of survivors suffer permanent disability.



Annual stroke incidence forecast to grow by +80% by 2050, due to aging demographics and rising risk factors (such as obesity, diabetes).



Estimated annual direct and indirect costs of stroke expected to grow to over US\$1.6 trillion by 2050.

**There are effective treatments for stroke, but they are time-sensitive and require determination of stroke type**

# TWO STROKE TYPES REQUIRE DIFFERENT CARE PATHWAYS

*Confirmation of stroke and stroke type required before reliable triage, transfer or treatment decisions can be made*

## Ischaemic Stroke Care Pathway Decisions

### Triage / Transfer

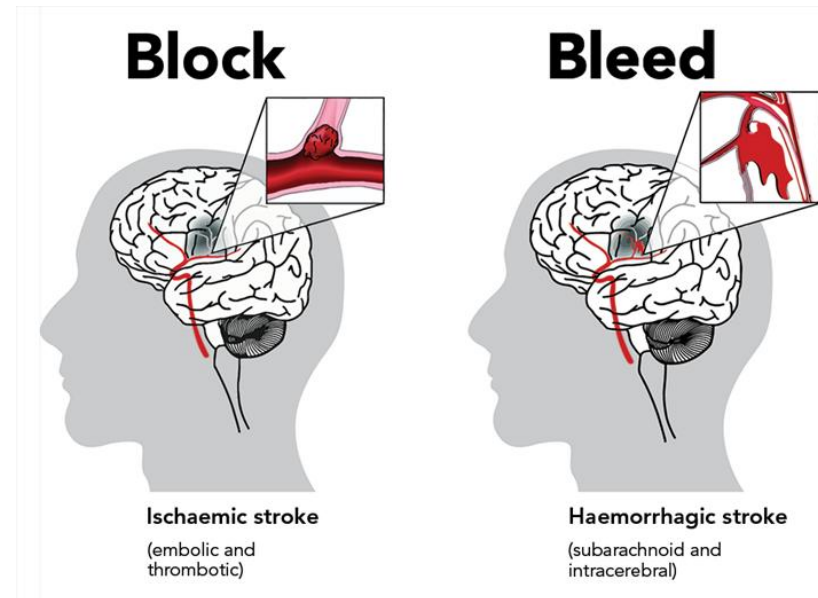
If thrombectomy (clot retrieval) is required, not every hospital can perform this, usually only comprehensive stroke centres

### Medication

Intravenous thrombolysis to dissolve blood clots and restore blood flow

### Surgical Intervention

Mechanical thrombectomy procedure to remove blood clots from blocked blood vessels to restore blood flow



**'Time is brain'**

## Haemorrhagic Stroke Care Pathway Decisions

### Triage / Transfer

Requires access to a neurosurgical team and neurocritical care, which is often limited to major tertiary hospitals

### Medication

Early blood pressure lowering and reversal of anticoagulation can limit hematoma expansion and secondary brain injury

### Surgical intervention

To decompress mass effect and prevent herniation

### Challenge #1:

Suspected stroke patients (including 'stroke mimics' that are not true strokes) present with similar symptoms

### Challenge #2:

Treatments must be administered as quickly as possible from symptom onset, but require stroke differentiation



# IN STROKE ‘TIME IS BRAIN’

*Modern stroke treatments are highly effective but time critical*

## Haemorrhagic Stroke

- Early **blood pressure reduction** associated with **25% lower odds** of a poor functional outcome compared to usual care.
- **Anticoagulation reversal** within 60 minutes of arrival associated with **18% relative reduction** in odds of death.
- Only **1 in 3 eligible patients** receive reversal treatment within 60 minutes of hospital arrival.

## Ischaemic Stroke

- **Thrombolysis** administered in the first 90 minutes from symptom onset **doubles the odds** of a good outcome.
- Each 15-minute reduction yields around 4–5% **higher odds** of walking independently at 3 months.
- Only a **small minority** of IVT-treated patients (<10%) receive thrombolysis within 90 minutes of symptom onset.

- In the HERMES analysis of 1,287 patients across 5 randomized trials, the median time from stroke onset to thrombectomy puncture was **~4 hours**.
- Each hour saved from symptom onset and intervention **increases odds** of achieving functional independence by **22–25%**.
- Only **1 in 3 patients eligible** for thrombectomy receive this treatment.

**Better functional outcomes result in fewer complications and readmissions, shorter hospital stays, and reduced care needs, lowering the burden and cost to healthcare systems**

### Sources:

INTERACT-4 study, Li et al. 2024.  
Sheth et al., “Time to Anticoagulation Reversal and Outcomes After Intracerebral Hemorrhage,” JAMA Neurology (2024).

### Sources:

Saver JL, “Time is Brain—Quantified,” Stroke, 2006.  
Fonarow GC, et al. “Door-to-needle times for tissue plasminogen activator administration and clinical outcomes in acute ischemic stroke.” Circulation. 2011;123(7):750–758.

### Sources:

Saver JL, Goyal M, van der Lugt A, et al. “Time to Treatment With Endovascular Thrombectomy and Outcomes From Ischemic Stroke: A Meta-analysis.” JAMA. 2016;316(12):1279-1288.  
Rai AT et al., J NeuroIntervent Surg, 2022 (U.S. estimates, MT trends).

# TODAY TRADITIONAL NEUROIMAGING IS REQUIRED FOR STROKE DIAGNOSIS

*Conventional CT imaging is highly important in stroke care but is not widely accessible at the point-of-care*

**EM**VISION



## Conventional CT

- Fixed location (hospital only)
- Heavy (1,800 – 2,700 kg)
- Ionizing radiation
- Complex to operate (radiographer & infrastructure)
- Considerable capex and opex

Mobile Stroke Units (MSUs) are custom-built ambulances fitted with a mobile CT



## Mobile CT Scanner

- Mobile (pre-hospital)
- Heavy (450 – 1,000 kg)
- Ionizing radiation
- Complex to operate (radiographer & infrastructure)
- Considerable capex and opex



## emu™

- Portable (in-hospital)
- Light (< 100 kg)
- Non-ionizing
- Easy to use (trained healthcare professional)
- Cost effective (< US\$200,000)



## First Responder

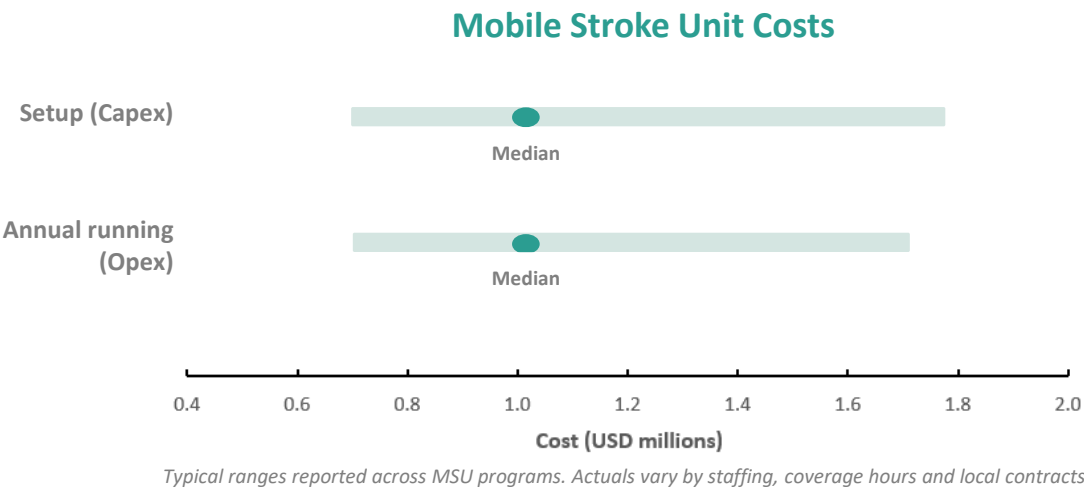
- Portable (pre-hospital)
- Light (< 12 kg)
- Non-ionizing
- Easy to use (trained healthcare professional)
- Cost effective (< US\$100,000)

**EMVision products are not designed to replace CT or MRI but to fill a gap where CT or MRI is inaccessible or unavailable**

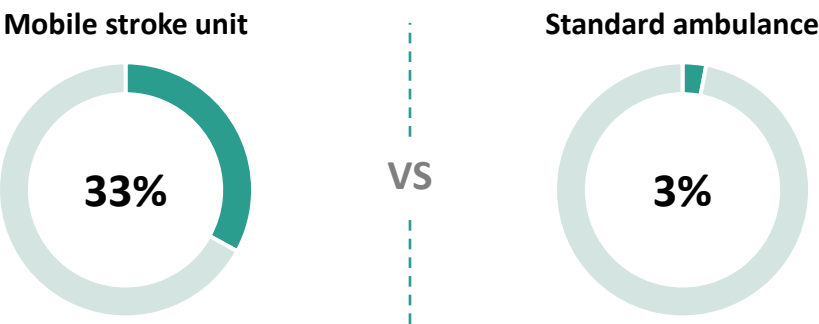
# EVIDENCE SUPPORTS PRE-HOSPITAL STROKE CARE

Mobile stroke units (MSUs) have demonstrated significant reductions in post-stroke disability and mortality

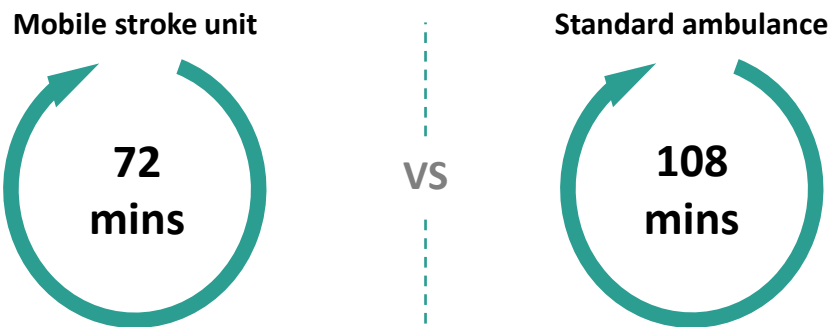
- With onboard imaging and specialist personnel, MSUs deliver hospital-grade stroke diagnostics and treatment at the scene, effectively transforming the ambulance into a mobile emergency department.
- Studies show that early treatment of stroke in MSUs are associated with significantly better functional outcomes than standard management with emergency medical services.
  - According to data pooled from five controlled studies around the world (n=3,228), patients treated in MSUs had a 64% higher chance of functional independence at 90 days.
- Widespread adoption requires a scalable and cost-effective solution.



## Stroke patients treated within first 'golden hour'



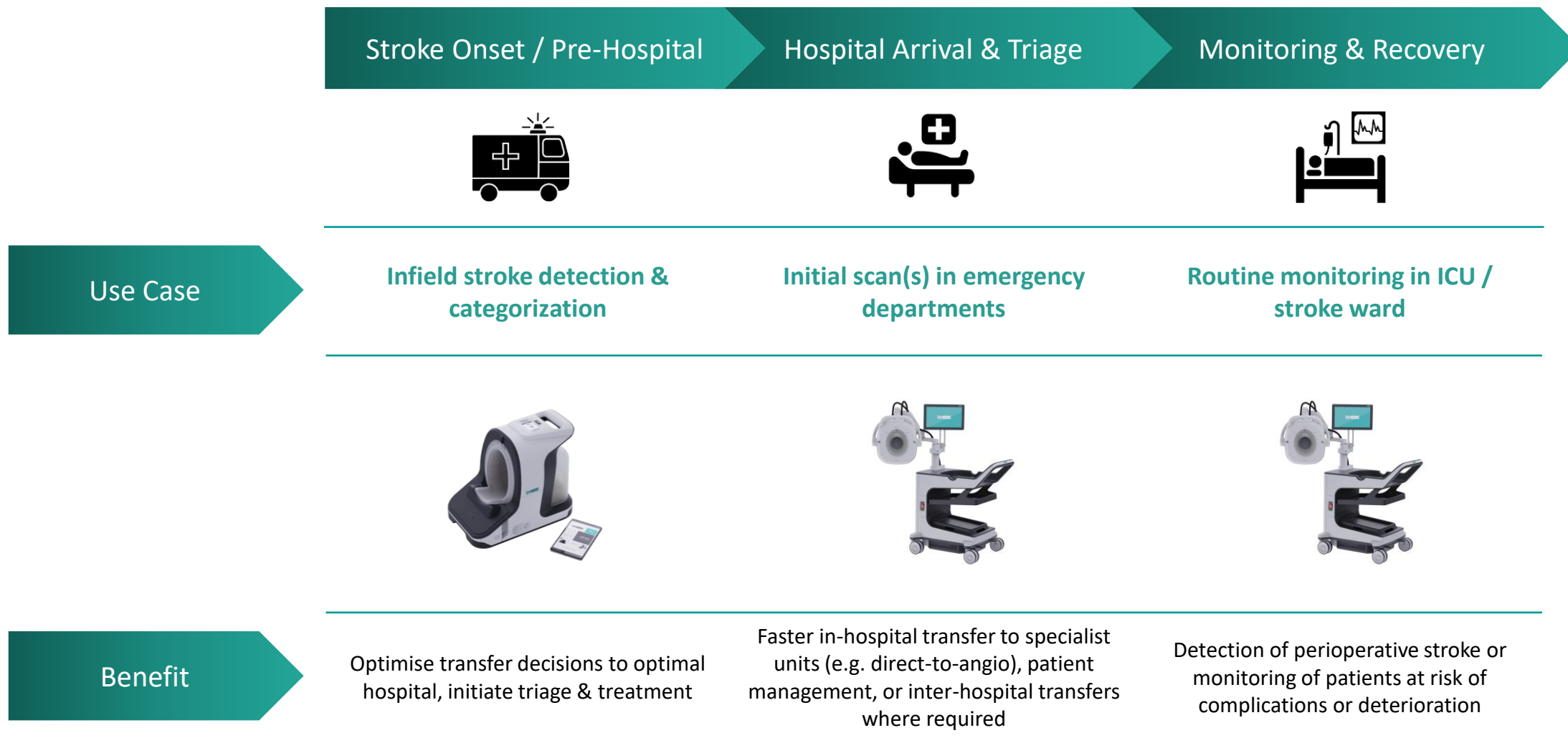
## Median stroke onset to needle time



Sources:  
Grotta, J. C., Yamal, J. M., Parker, S. A., et al. Prospective, multicenter, controlled trial of mobile stroke units. *N Engl J Med.* 2021;385:971–981.  
Jackie Drees, "How to Roll Out a Mobile Stroke Unit," *HealthLeaders Media*, February 13, 2019.  
Hiroki M, Kohno M, Kohno Y, Misawa M. Practical Status and Social Background of Current Mobile Stroke Units Worldwide: A Survey and Investigation. *West J Emerg Med.* 2025;26(3):700–711.  
Turc G, Hadziahmetovic M, Walter S, et al. "Comparison of Mobile Stroke Unit with Usual Care for Acute Ischemic Stroke Management: A Systematic Review and Meta-analysis." *JAMA Neurology* 79, no. 3 (2022): 281–290.

# EMVISION IN THE STROKE CARE PATHWAY

*Our mission is to help minimize time to treatment or intervention by bringing decision making to the patient's location*



# STRONG CLINICAL DATA

Positive ‘EMView’ results & FDA engagement provided confidence to proceed with Pivotal (Validation) Trial

**Participants** • 307 (277 suspected stroke patients, 30 healthy patients).

**Sites** • Liverpool Hospital, Royal Melbourne Hospital and the Princess Alexandra Hospital.

**Endpoints** • Hardware verification, safety, and AI algorithm enhancements.

**Highlights** • Diagnostic algorithms tested on unseen data demonstrated high performance.  
• AI based diagnostic models demonstrated steadily improved performance as additional training data was provided.  
• Case studies highlight exceptional sensing capabilities, including successful detection and classification of very small haemorrhages.

*"The results are very encouraging, particularly as related to detection capabilities and sensitivity to small haemorrhages. We look forward to confirmation of this impressive neurodiagnostic capability in the validation trial."*

Co-chairs of Australian Stroke Alliance, Professors Geoffrey Donnan and Stephen Davis

‘Haemorrhage or not’	Haemorrhage	Not Haemorrhage
Total Test Cases	13	55
Correctly Identified Cases	12	47
Performance	92% Sensitivity	85% Specificity

‘Ischaemia or not’	Ischaemic	Not Ischaemic
Total Test Cases	20	50
Correctly Identified Cases	19	40
Performance	95% Sensitivity	80% Specificity

## Comparative Performance of Commonly Used Tools in Stroke Care

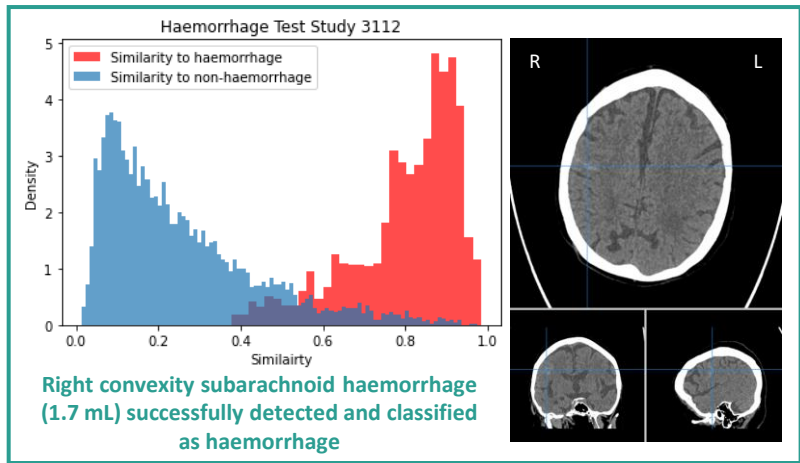
	Sensitivity	Specificity
<b>Stroke scales</b> (LAMS-4 higher likelihood LVO)	69%	81%
<b>Non-contrast CT</b> (for acute ischaemic stroke)	39% – 70%	> 90%
<b>Contrast enhanced CT</b> (for acute ischaemic stroke)	80% – 90%	> 95%
<b>Non-contrast CT</b> (for haemorrhagic stroke)	90% – 99%	> 95%



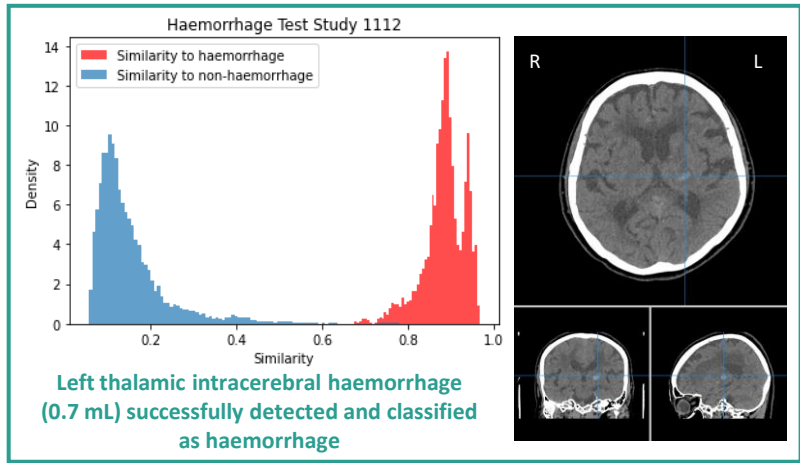
# 'EMVIEW' CASE STUDIES

Highlight exceptional sensing capabilities, including successful detection and classification of very small strokes

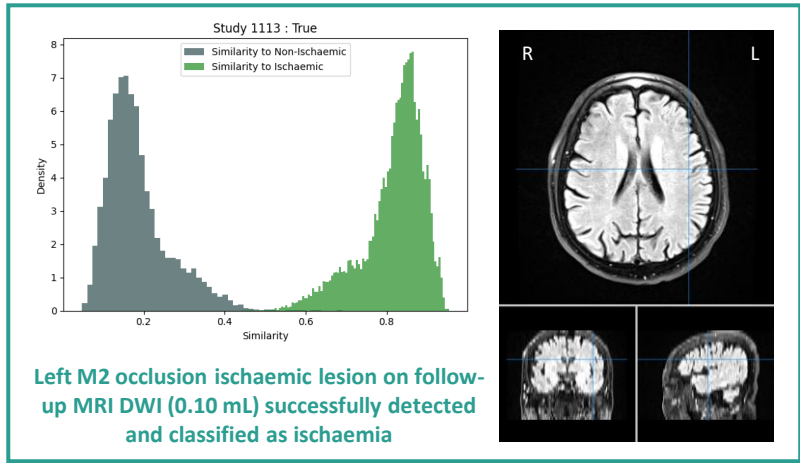
Case #1



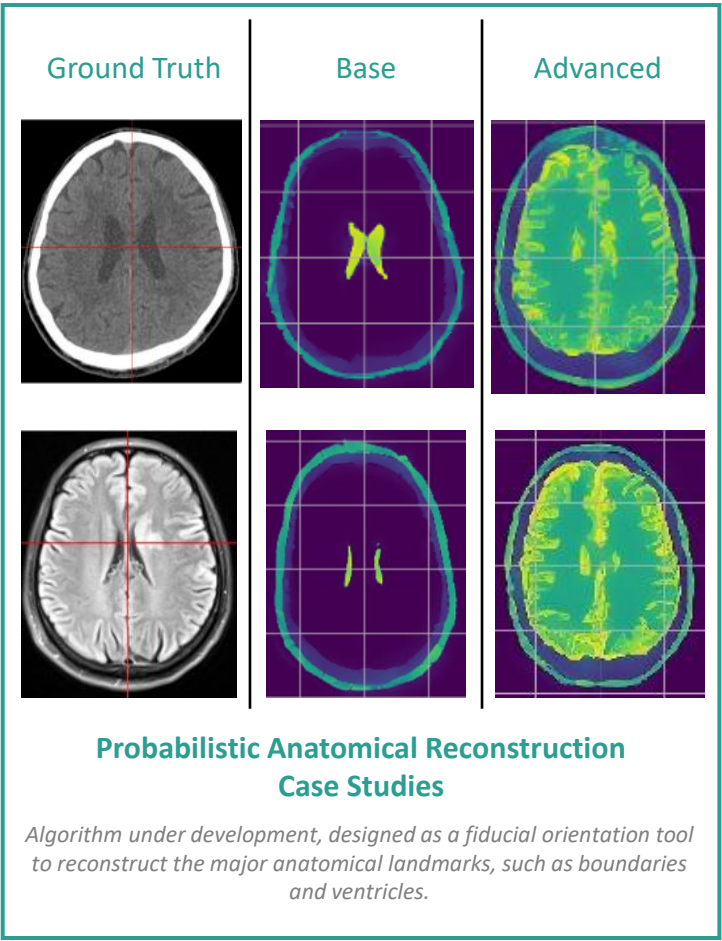
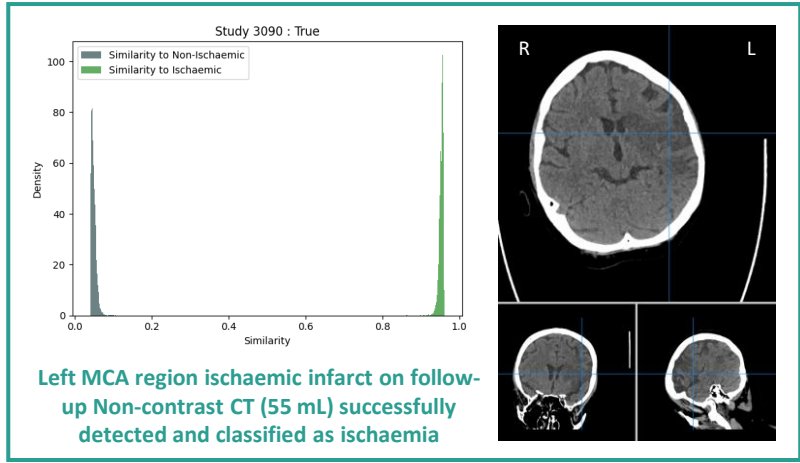
Case #2



Case #3



Case #4



The median reported haemorrhage volume is 14 mL.  
75% of haemorrhage volumes exceed 3.8 mL (Robinson et al., 2021)

# COLLABORATIONS & GRANT SUPPORT

*Established history of securing valuable industry collaborations and grants*

## Industry Collaborations



### Product Collaboration, Substantial Shareholder

Strategic product collaboration and supply for bespoke measurement technology within EMVision's Brain Scanners and equity investment (Keysight invested \$15m at \$2.05 in February 2024).



### Clinical Expertise, Development and Validation

A consortium of over 40 organisations that have come together to transform pre-hospital stroke care. The \$55 million program brings together novel technology (including EMVision's portable brain scanners) with workforce education and cloud-based telemedicine.



### Inception Member

NVIDIA Inception nurtures dedicated and exceptional startups who are revolutionizing industries with advances in AI and data science.

## Previous Grants



NSW Medical Devices Fund  
\$2.5m



Modern Manufacturing Initiative  
\$5.0m



Cooperative Research Centre Project

\$3.5m



GE Healthcare

## Current Grants



Australian Government  
Department of Industry,  
Science and Resources

Industry Growth Program  
AusIndustry

\$4m (remaining)



Australian  
Stroke Alliance

\$0.4m (remaining)

### emu™ (in-hospital)



Australian Government  
Department of Industry,  
Science and Resources

Cooperative Research  
Centres Program

\$3m (remaining)

Regional benefits study in South Australia hospitals conducted with emu™ with telehealth integration, to demonstrate ability to provide more timely stroke diagnosis.



EMVISION



Australian  
Stroke Alliance



Government  
of South Australia  
SA Health




# MARKET OPPORTUNITY

Multi-billion dollar addressable market for emu™ and First Responder






## emu™ Addressable Market

### HOSPITALS

US	GER, FRA, UK	AUS	Dev. ASIA
			
10,200	5,960	545	12,850

Number of devices per hospital will vary depending on clinical demand and onsite capabilities.

### HIGH PRIORITY TARGETS

		
Comprehensive Stroke Centers	Primary Stroke Centers	Critical Access Hospitals
200 – 300	1,400 – 1,700	1,300 – 1,500





## First Responder Addressable Market

### ROAD & AEROMEDICAL AMBULANCES

US	GER, FRA, UK	AUS	Dev. ASIA
			
60,000	58,000	5,200	8,300



### HIGH PRIORITY TARGETS

		
Aeromedical Ambulances	Academic EMS & Specialized Units	Advanced Life Support Ambulances
1,500 – 1,800	2,000 – 4,000	18,000 - 20,000


EMV cautions investors that there are regulatory barriers and unique access challenges to each market and can be subject to varying rates of penetration. The High Priority Targets have been identified by the Company as part of its target addressable market, which will inform the Company's long-term development and commercialisation strategy and are not indicative of future sales. Investors are cautioned that there are no guarantees that the high priority targets will be converted into future sales. Addressable market sources: estimates based on ABS, U.S Census Bureau, WHO, AHA, EMS data and other publicly available data..

# REVENUE MODEL

*Capital equipment & consumables model, complemented by monthly subscription offering where preferred*



Coupling media



Disposable cap

Capital Equipment	US\$150,000 - \$200,000 (target price range)
Consumables	Disposable infection prevention cap & coupling media US\$25 per scan (target price)
Service Contracts	Preventative maintenance, servicing & software upgrades ~10% of equipment per year (target price)

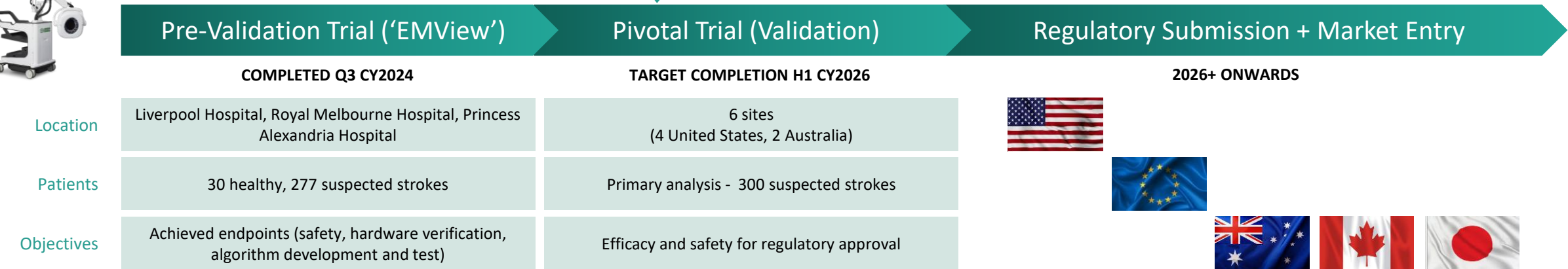


Capital Equipment	US\$50,000 - \$100,000 (target price range)
Consumables	Disposable infection prevention cap, coupling media US\$50 per scan (target price) Additional accessories: batteries, charging dock, carry case
Service Contracts	Preventative maintenance, servicing & software upgrades ~10% of equipment per year (target price)

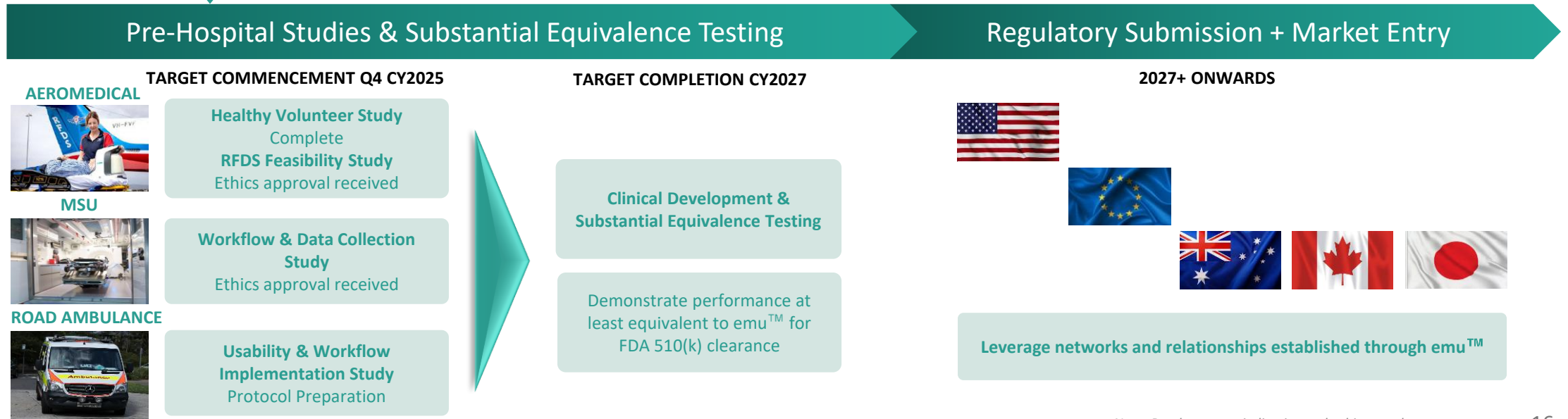
# MARKET ACCESS ROADMAP



We are here



We are here



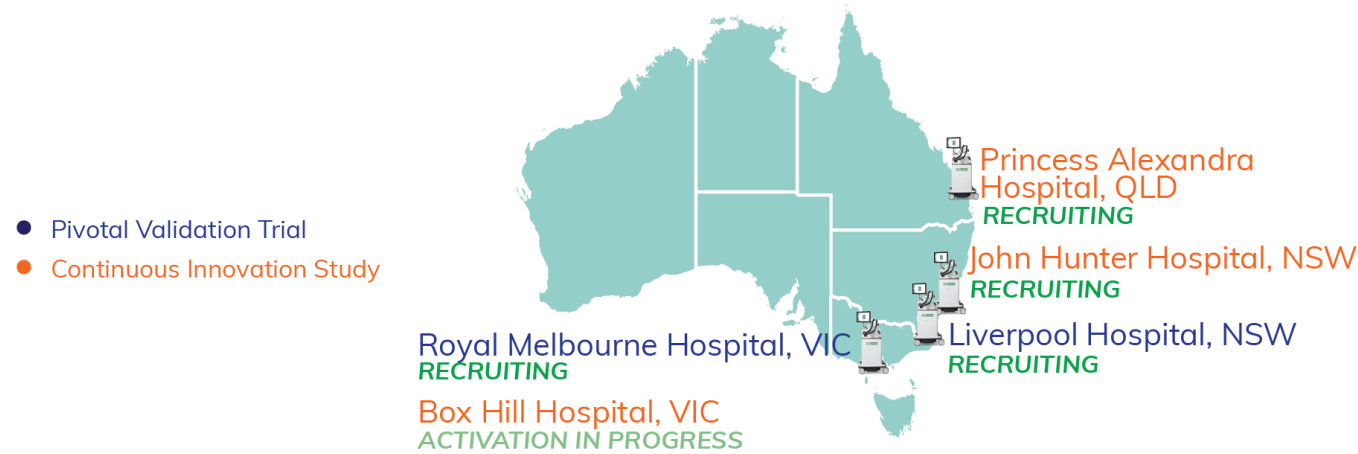
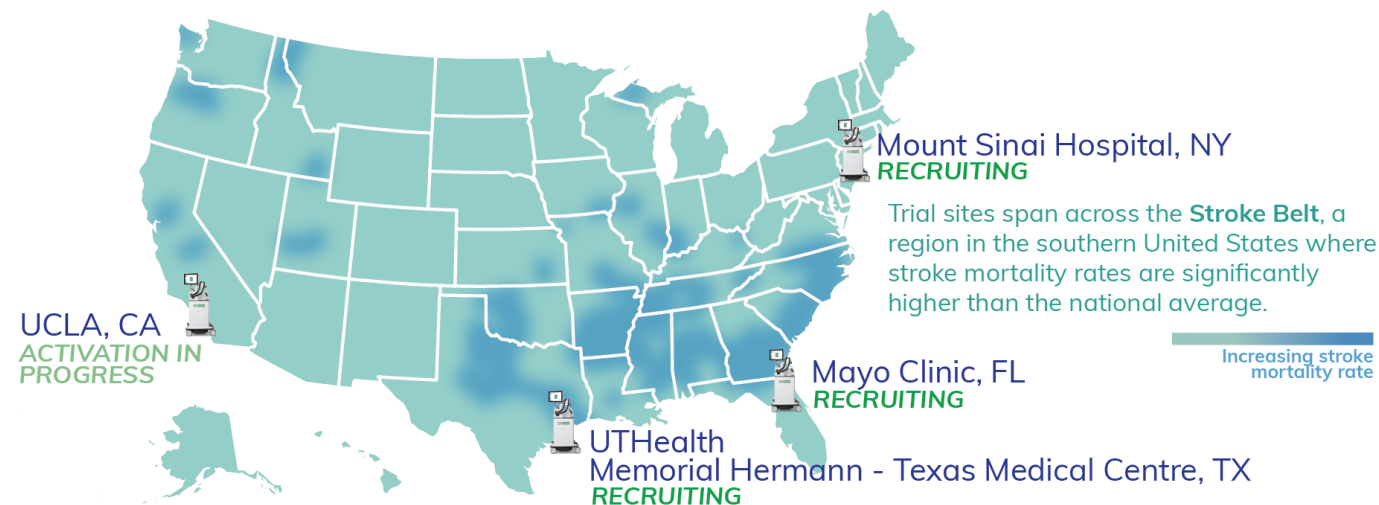
Note: Roadmaps are indicative and subject to change.



# emu™ CLINICAL ROADMAP

Pivotal (Validation) Trial	
Participants	300 suspected stroke patients (primary analysis) (including 150 intracranial haemorrhages)
Sites	Comprehensive Stroke Centres (4 US, 2 AU sites)
Primary Endpoint	Detection of haemorrhage (>80% sensitivity / 80% specificity)
Recruitment	Target completion H1 CY2026
Objective	Support emu™ FDA De Novo clearance

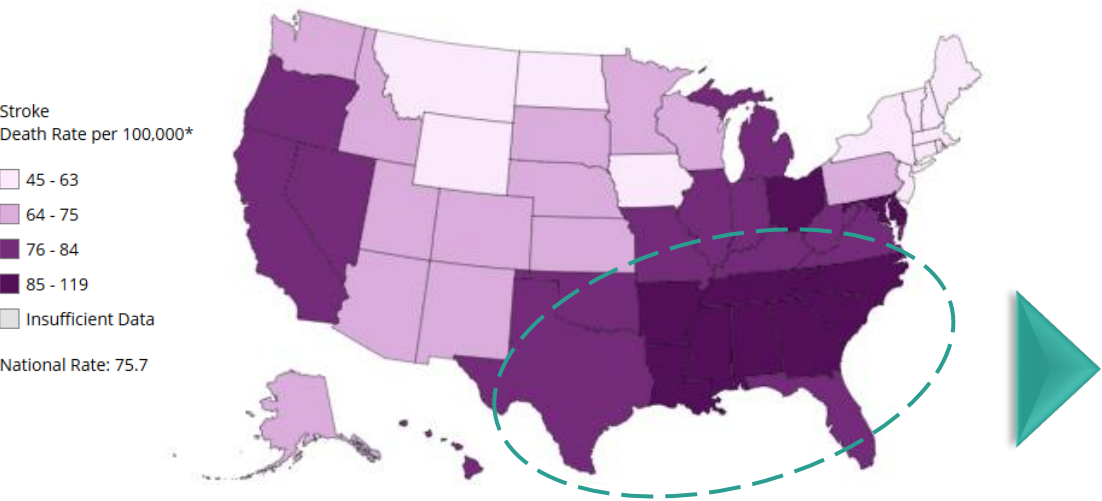
Continuous Innovation Study	
Participants	Up to 300 suspected stroke & TBI patients
Sites	Comprehensive Stroke Centers + Level 1 Trauma Centres (3 AU sites)
Endpoints	Data for algorithm advancement
Recruitment	Runs in parallel with Pivotal trial
Objective	Expand emu™ features and indications



# INITIAL COMMERCIALISATION STRATEGY

Targeted launch into the US expanded 'Stroke Belt'

## Market Launch



22% higher death rate from stroke than rest of US

The 'Stroke Belt' is a region of 11 states (plus Texas and Florida) in the Southeastern US that has demonstrated significantly higher stroke incidence and mortality rates compared with other regions since at least 1940.

\*Note: Rates are age standardized and spatially smoothed 3-year averages (2019-2021, ages 35+).  
Source: National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention.

Addressable market sources: The Joint Commission, Definitive Healthcare, National Emergency Medical Services Assessment and other publicly available data.

## High Priority Stroke Belt Targets



Comprehensive Stroke Centers  
70

Primary Stroke Centers  
400

Critical Access Hospitals  
330



Aeromedical Ambulances  
980

Academic-affiliated EMS & Special Units  
1,600

Advanced Life Support Ambulances  
4,000

The High Priority Targets have been identified by the Company as part of its target addressable market, which will inform the Company's long-term development and commercialisation strategy and are not indicative of future sales. Investors are cautioned that there are no guarantees that the high priority targets will be converted into future sales.

# INITIAL COMMERCIALISATION STRATEGY

*Disciplined and insight-driven approach, with phased execution roadmap*

## Sales Model

- Commence with dedicated, high-touch direct service to build strong strategic relationships with key opinion leaders and early adopters.
- Establish clinical trust and market credibility.
- Maintain ownership of customer service, training and education, as well as unit economics.
- Direct access to user feedback and market intelligence to inform product and strategy refinement.

**Risk-aware strategy which balances the scale of the commercial opportunity with the complexities of the US healthcare system**

## Reimbursement Strategy



### Temporary

### Permanent

#### New Technology Add-On Payment

- Reimbursed up to 65% of total cost.
- Applies for up to 3 years.
- Criteria – new, cost, substantial clinical improvement.

- Major Hospitals**
- Bundled payment per Diagnosis Related Group.
- Rural Critical Access Hospitals (< 25 beds)**
- Medicare reimburse 101% of reasonable costs.



### Temporary

### Permanent

#### New Technology Ambulatory Payment Classifier

- Customized to facility cost of the new procedure and technology.
- Applies for 2+ years.
- Key criteria – Procedure is reasonable and necessary with no current coding to describe the procedure.

- Ambulatory Payment Classifier**
- Payment mapping from provider cost of procedure and use of technology.
  - Initial reimbursement level as per costs demonstrated during NTAPC period.

# LONGER TERM GROWTH STRATEGY

*Initial US launch used as playbook for national scaling, geographic expansion and indication extension*



## US National Penetration

Controlled national rollout, prioritizing regions with the greatest unmet need and readiness for adoption.

Supported by dedicated commercial, clinical, and operational teams. Ability to scale salesforce directly or appoint a distributor under a hybrid model.

Strengthen clinical advocacy and data for value analysis committees (VACs) by generating post-approval data demonstrating clinical utility and economic benefit to hospitals.



## International Expansion

Establish initial European presence in the Nordics and DACH countries, capitalizing on their advanced, well funded healthcare systems and commitment to innovation, before scaling into the rest of Europe.

In Australia, leverage Australian Stroke Alliance partnership and excellent local clinical relationships, to support domestic roll-out and adoption.

Selective expansion in Asia and ROW, targeting countries with innovative health systems and clinical needs.



## New Indications

Traumatic Brain Injury (TBI) is highly prevalent globally, especially in emergency departments and pre-hospital care, adding significant new patient populations beyond stroke.

Expanding into TBI meaningfully enlarges the addressable market and consumable opportunities by accessing high-volume trauma channels.

Stroke indication regulation clearance can also be leveraged, given safety and performance precedents.

# COMMERCIALISATION ENABLERS

*EMVision's path to market built around six core pillars*



## 1. Compelling value proposition

Building persuasive clinical data and value proposition for our devices



## 2. Leading collaborations

With top tier institutions, clinicians and key opinion leaders in stroke care



## 3. Reimbursement strategy

Targeting innovative payments programs for initial reimbursement certainty



## 4. Market engagement

Extensive market education via publication, presentation and podium strategy



## 5. In-house production

Established production capabilities at Macquarie Park, Sydney office



## 6. Commercialisation strategy

Targeted and phased market entry strategy, prioritising existing relationships



# UPCOMING MILESTONES

Transitioning from R&D focus to preparation for market access and commercialisation

## emu™ and First Responder Clinical Programs

H2 CY2025



### Pivotal (Validation) Trial

Progress updates

### Continuous Innovation Study

Progress updates

### Aeromedical Study

Commencement, Progress updates, Reporting

### Mobile Stroke Unit Study

Commencement, Progress updates

### Road Ambulance Study

Commencement



1H CY2026

### Pivotal (Validation) Trial

Progress updates, Reporting

### Continuous Innovation Study

Progress updates, Reporting

### Regional Benefits Study

Preparation, Commencement

### Mobile Stroke Unit Study

Progress updates, Reporting

### Road Ambulance Study

Progress updates, Reporting

### Production Equivalent Device

Commercial production translation, Progress updates

Regulatory Body Engagement

## Ongoing Value Drivers

### Podium Strategy

Conferences, journal publications, exhibitions

### Market Entry Strategy

Commercialisation and go-to-market preparation, strategic relationships

### Grant Strategy

Active pipeline of potential non-dilutive funding opportunities

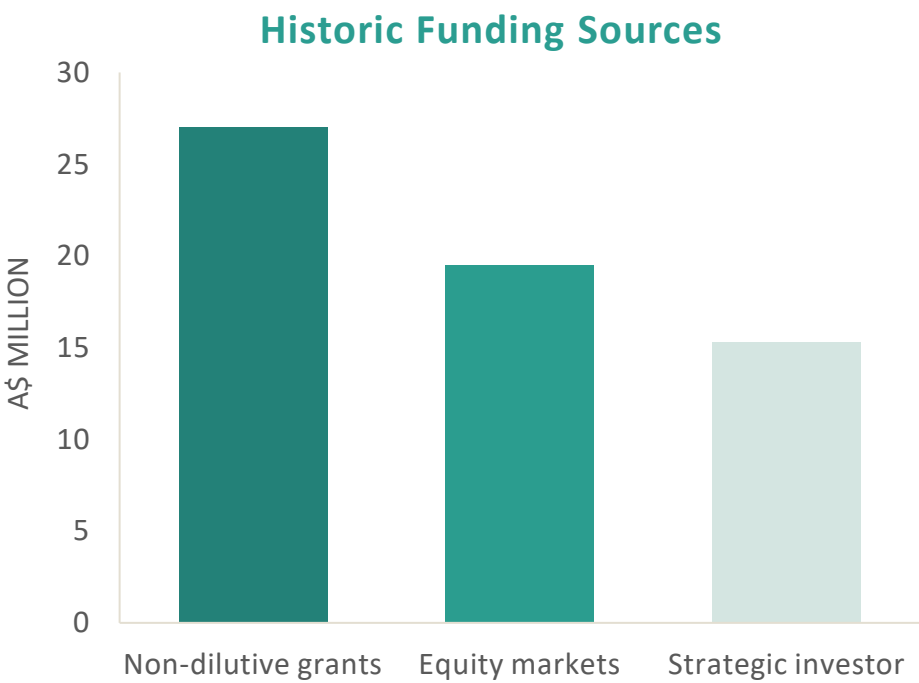
### Production Strategy

Expand production capabilities including establishment of First Responder pilot production line

# CAPITAL STRUCTURE

ASX Ticker: EMV	
Share Price (5 September)	\$1.99
Shares on issue	85,516,535
Total Options on issue	4,200,000
Market Capitalization	\$170.2m
Enterprise Value	\$159.7m
Cash balance (30 June 2025)	\$10.5m
Remaining non-dilutive grants	\$7.4m
Previous R&D rebate	\$2.1m
FY25 quarterly cash burn (net of non-dilutive funding)	~\$2m

## Strong Capital Management Track Record



### Substantial shareholders:

Keysight Technologies (NYSE:KEYS)	8.7%
Scott Kirkland (CEO/Co-founder)	5.0%



# APPENDIX

# CLINICAL FEEDBACK



## Professor Geoffrey Donnan AO

Stroke Neurologist  
Co-chair ASA, Past-President of World Stroke Organization

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



## Professor Stephen Davis AO

Stroke Neurologist  
Co-chair ASA, Past-President of World Stroke Organization

“The concept of bringing imaging to the patient will dramatically reduce times to administer life saving interventions such as thrombolysis and thrombectomy.”



## Dr Mardi Steere

Executive General Manager Medical and Retrieval Services, Royal Flying Doctor Service

“Equitable healthcare for patients in remote areas needs to overcome the tyranny of distance. Portable brain imaging is a crucial next step in bringing critical care to patients sooner.”



## Dr Dennis Cordato

Stroke Neurologist, Liverpool Hospital, Sydney  
Principal Investigator for ‘EMView’ Trial

“This is an exciting development in stroke and neurological care. We have found the EMVision scanner to be a very user-friendly portable imaging modality. The EMVision scanner has potential for wide application in both the prehospital and acute hospital settings.”



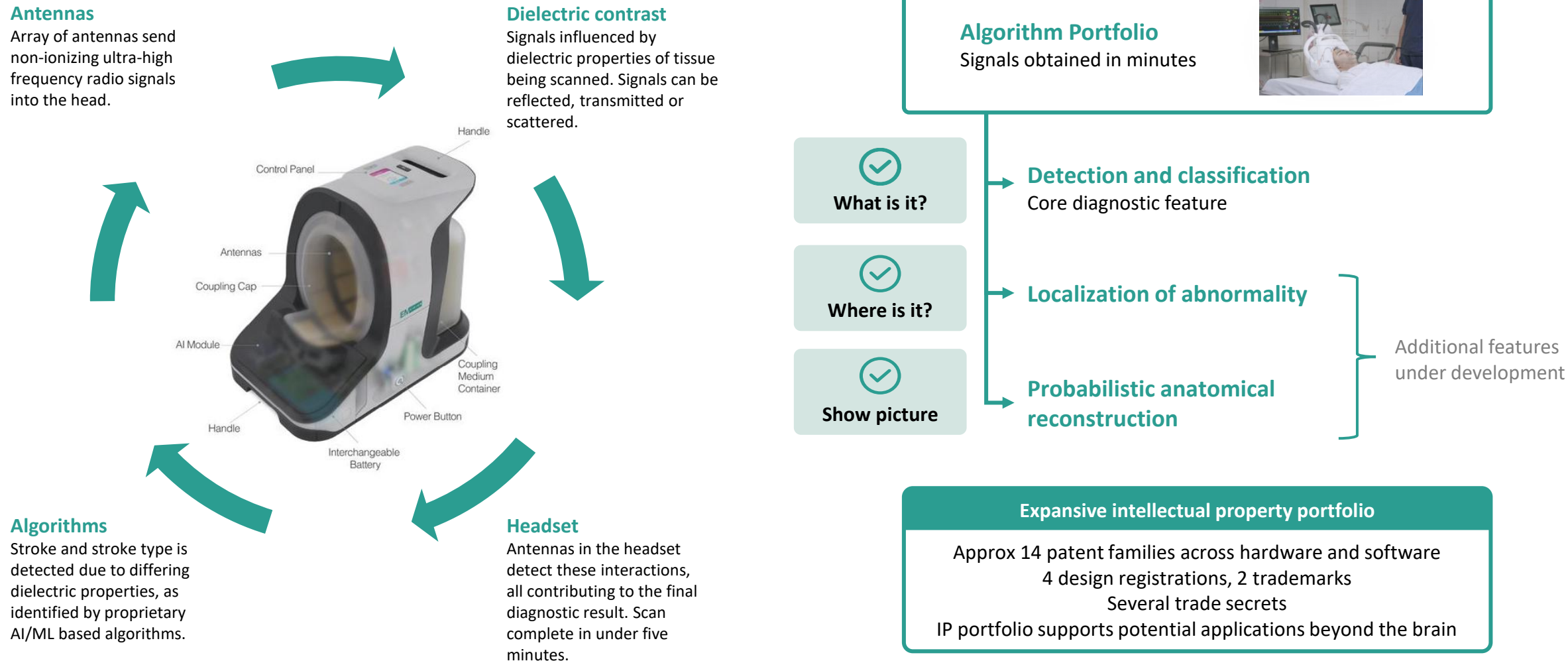
## Dr Reade De Leacy

Neurointerventional radiologist,  
Neuroendovascular surgeon and co-director of  
the Neuroendovascular Surgery Fellowship at  
Mount Sinai

“The pivotal trial represents a critical step in validating the diagnostic performance of EMVision's emerging modality for point-of-care stroke diagnosis. By enabling rapid differentiation of suspected stroke type at the point-of-care, the technology has the potential to significantly reduce time to treatment and intervention to improve patient outcomes in both pre-hospital and in-hospital settings.”

# TECHNOLOGY OVERVIEW

*Mobile and rapid neurodiagnostic modality for pre-hospital and bedside evaluation*





# OPPORTUNITIES TO IMPROVE STROKE CARE

*Point-of-care diagnostics support effective decision-making when traditional neuroimaging is not available*

## Where should we take this patient?

Stroke treatment capabilities differ between hospitals and geographies

## Can I initiate stroke therapies in the field?

Effective treatments exist, but first require stroke and stroke type determination

## Who should be prioritized?

Medical personnel and neuroimaging are limited resources, limit over-triage

## Is the angio suite ready?

Early preparation and awareness decreases time to definitive patient treatment

## Stroke onset

## Patient Deterioration

## Neuroimaging + Stroke Care

## How do I manage the patient?

Some medications have demonstrated benefits in specific stroke types

## Is the hospital stroke team prepared?

Pre-notifications help coordinate between first responders and hospitals

## Should we transfer this patient?

Transfers to hospitals with neuroendovascular capabilities may be needed

## Is the patient deteriorating?

Identify signs of changes earlier that can be acted upon sooner

**Delays and inefficiencies at all stages of the stroke care pathway lead to delayed definitive treatment and worse outcomes for patients who could otherwise be saved**

# POTENTIAL BENEFITS TO HOSPITALS

*Prospective cost savings from optimised workflows and resource utilization*

## Health Economic Assessment

Estimated potential financial benefits of an emu™ to a public hospital in Australia:

Reduction in Transportation Costs	\$120,000
More efficient CT/MRI Utilization	\$150,000
Improvement in Endovascular Clot Retrieval Resource Utilization	\$90,000
Reduction in Length of Patient Stay	\$78,000

If these benefits are realized, potential for cost of emu™ device to be covered in first year of ownership

Estimated Annual Total Financial Benefit of one emu™ device  
(excluding device cost)

\$438,000

*The above numbers are based on an indicative model 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. While the Company is not aware of any information or data that materially affects the information contained in the assessment, the material assumptions remain reasonable, yet given the study was undertaken in August 2021, 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.*



Research & Modelling conducted by:



# SECOND INDICATION IN TRAUMATIC BRAIN INJURY

*Significant unmet clinical need for TBI screening*

- Each year, **over 50 million people** sustain a suspected TBI, with the estimated cost to the world economy upwards of **\$400 billion**.
- An estimated **90% of head CT scans** in patients suspected of having mild TBI **have negative results** for clinically important brain injuries.
- In 2010, FDA launched an initiative to reduce **unnecessary radiation exposure** from medical imaging. Head CT, the default test for suspected TBI, uses ionizing radiation that carries a small but real lifetime cancer risk.
- Reducing unnecessary CT scans reduces length of stay and emergency department congestion, and can **save healthcare system thousands** of dollars per CT.
- Clinicians are also seeking to **prioritise urgent care for true TBI cases** that require potentially life-saving intervention, as well as closer patient monitoring opportunities.

## Existing FDA cleared solutions for point-of-care TBI assessment

### Brainscope TBI

EEG based device intended to identify cases of mild TBI (GCS 13-15) that would likely be positive for structural brain injury on CT

Sensitivity: **92.3%**, Specificity: **51.6%**

### Abbott i-STAT TBI

Blood biomarker (GFAP and UCH-L1) intended to identify cases of mild TBI (GCS 13-15) that would likely be positive for acute traumatic intracranial lesion

Sensitivity: **96.5%**, Specificity: **40.3%**

1. Levin, Z "Mild traumatic brain injury: Part 1: Determining the need to scan. *Can Fam Physician*. 2010 Apr;56(4):346-9.

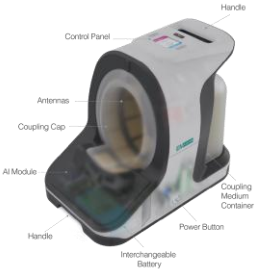
2. Smith-Bindman, R et al, "Projected Lifetime Cancer Risks From Current Computed Tomography Imaging" *JAMA Intern Med*. 2025 Jun 1; 185(6): 710-719.

3. Brainscope figures come from Academic Emergency Medicine multicenter validation study (Hanley et al., 2017).

4. Abbott i-STAT TBI figures come from the official Instructions for Use / FDA 510(k) materials and are intended to aid decisions about whether a head CT is needed

# FY25 HIGHLIGHTS

A landmark year across product, clinical, regulatory and corporate development



**First Responder**  
Advanced prototype device unveiled

**Positive FDA engagement**  
on Pivotal Trial design & regulatory strategy



**First Responder**  
Successful aeromedical volunteer testing

**emu Pivotal Trial**  
Mayo Clinic, FL site activated



**'EMView' study**  
presented at European Stroke Organisation Conference

**emu Pivotal Trial**  
Mount Sinai, NY and Liverpool Hospital, Sydney activated



**FDA pre-submission**  
to achieve alignment on emu Pivotal (Validation) Trial

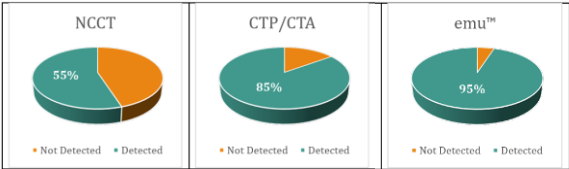


**Results of 'EMView' pre-validation study**  
Haemorrhage detection  
92% sensitivity & 85% specificity  
Ischaemia detection  
85% sensitivity, 78% specificity

**emu Pivotal Trial commenced**  
Royal Melbourne and UHealth activated



**Continuous Innovation program** improves Ischaemia detection results to 95% sensitivity and 80% specificity



**\$5m IGP Government grant** to accelerate First Responder commercialisation

**Carmel Monaghan** appointed Non-Executive Director, formerly CEO Ramsay Healthcare Australia