Good morning, everyone. I am pleased to welcome you to the webinar call for the first half results for FY26 for Epiminder Limited including year to date highlights. My name is Mark McLellan, and I am the CFO at Epiminder. I am joined by Rohan Hoare the CEO of Epiminder.

We will run through some slides for the next 10 to 15 minutes and then there will be an opportunity to answer any questions that you may have. There is a Q&A facility in the webinar so please send any questions you have at any time during the call, and we will look to address these at the end of the presentation.

I will now hand over to Rohan Hoare, the CEO of Epiminder.

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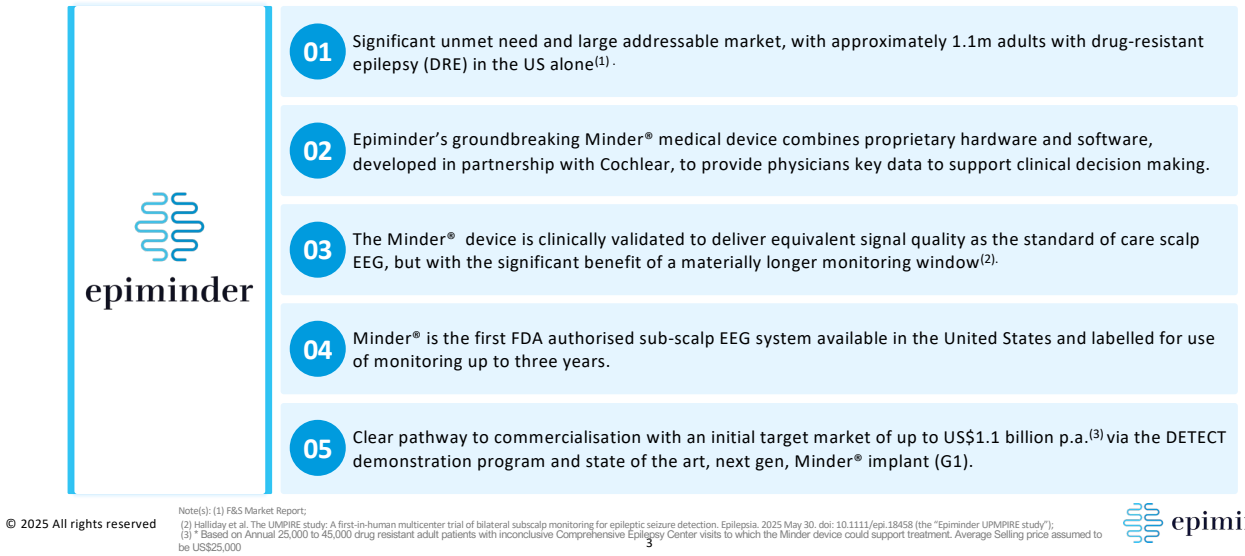
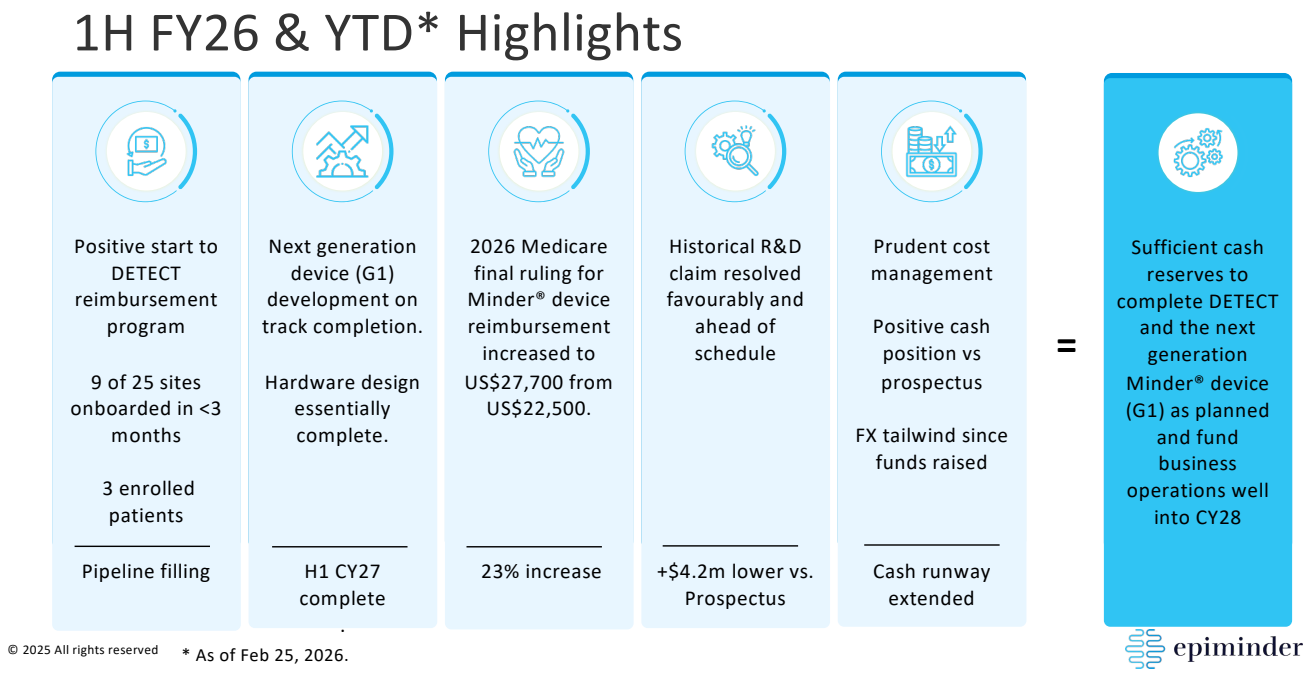


Thank you for joining us for the first half FY26 Epiminder conference call. I'm Rohan Hoare Epiminder's CEO and it is great to be able to provide an update on what has been happening since Epiminder was listed on 1 December last year.

Epiminder is pioneering a sub scalp EEG system for Drug Resistant Epilepsy. A couple of definitions - EEG or Electroencephalogram is the recording of the brain's electrical activity and DRE are the roughly 35% of epilepsy patients who continue to have seizures after trying 2 different seizure medications. Our sub scalp EEG system is called Minder and provides physicians with key data to support clinical decision making. There are approximately 1.1m adults with DRE in the US and 80-90k in Australia. The Minder system is the first and only FDA authorized implantable continuous EEG monitoring device (iCEM) in this population. The UMPIRE trial conducted in Australia and used for FDA authorization showed data from Minder informed clinical decision making in 88% of the study participants. The Minder system is clinically validated to the standard of care scalp-based EEG (days) with substantially longer monitoring windows of months to years of use. In fact, the first recipient of the Minder system in Australia has used the device for more than 6 years. The initial target market for the Minder system is approx. $1.1B annually for those DRE patients who receive inconclusive diagnostic testing with conventional monitoring at a Comprehensive Epilepsy Centers.

Epiminder completed its IPO on Dec 1st, raising $125m which is sufficient to fund the company well into CY28. We have made very good progress on operational and financial objectives.



* As of Feb 25, 2026.

Highlights from the first half

Positive start to DETECT reimbursement program with 9 clinical sites onboarded out of a max of 25 sites and 3 patients enrolled. Patient Pipeline is filling.

Next Generation device G1 development is on track for H1 2027 completion with Hardware design now essentially complete. FDA clearance expected H2 CY2027.

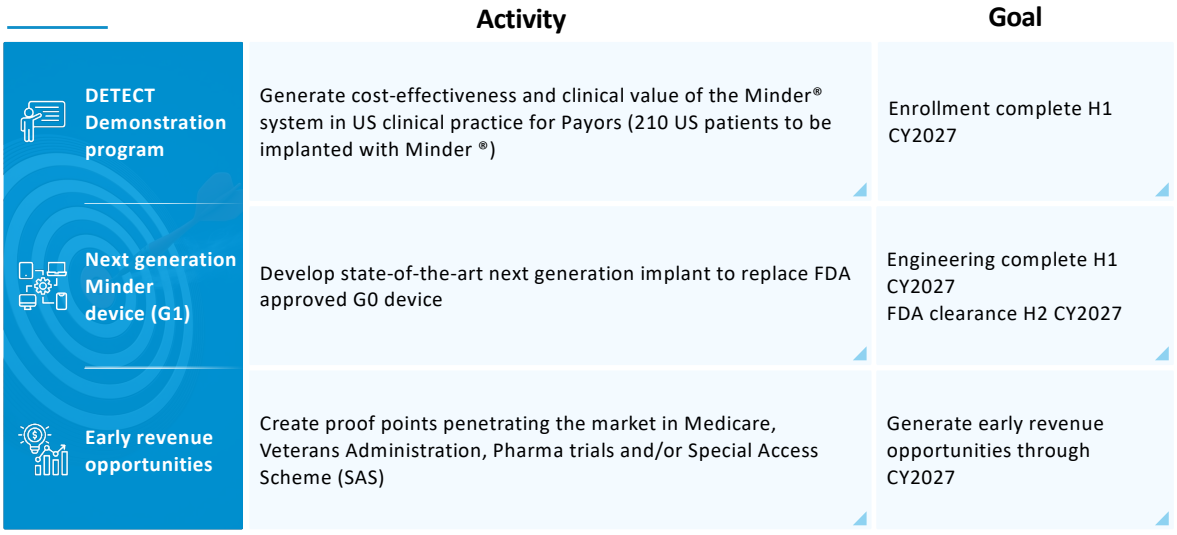
Medicare final rule for 2026 increased reimbursement for the Minder device to $27,700, an increase of 23% and another building block to support our average selling price of US$25k.

ATO tax liability resolved favourably and ahead of schedule. This has provided an additional $4.2m of cash.

Prudent cost management continues, ATO resolution and FX tailwinds have improved our cash runway compared to what was expected at the time of the IPO.

We project to have sufficient cash reserves to complete our two key priorities as planned, DETECT and FDA authorization of our next gen Minder devices and carry the company well into CY28.

Key objectives over next 24 months



	Activity	Goal
DETECT Demonstration program	Generate cost-effectiveness and clinical value of the Minder® system in US clinical practice for Payors (210 US patients to be implanted with Minder ®)	Enrollment complete H1 CY2027
Next generation Minder device (G1)	Develop state-of-the-art next generation implant to replace FDA approved G0 device	Engineering complete H1 CY2027 FDA clearance H2 CY2027
Early revenue opportunities	Create proof points penetrating the market in Medicare, Veterans Administration, Pharma trials and/or Special Access Scheme (SAS)	Generate early revenue opportunities through CY2027

Note(s): All milestones and associated target dates are management expectations based on current plans and are subject to change

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This slide identifies the main priorities, key activities and goals for Epiminder in CY2026 and CY2027. Our plan to drive the commercial opportunity for the business is to complete DETECT and G1 development by H1 CY2027.

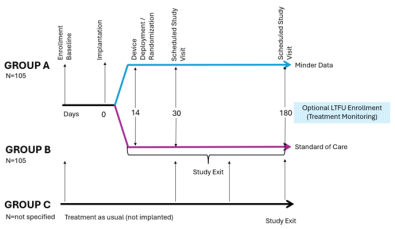
While getting DETECT in full swing is the immediate priority for the company, over the next 18 months we will seek to generate commercial proof point of penetrating the market with Medicare, Veterans Affairs in the US, Pharma and in Australia with the Special Access Scheme.

I will now go through these two major priorities in more detail.

DETECT demonstration program

Expected use of funds $25m over next 24 months

Primary objective	Demonstrate the cost-effectiveness and clinical value of the Minder® system in US clinical practice
Primary endpoint	Validate the proportion of actionable events captured by Minder® relative to the current standard of care
Program design	Randomised control multi-center study for 6 months duration (~24 months including set up for long-term follow-up)
Program population	210 subjects, eligibility based on suspected or confirmed diagnosis of epilepsy and at least 1 previous inconclusive multi-day 10-20 scalp EEG
Program sites	Up to 25 leading US epilepsy centres
Follow up	Follow-up assessments at 1 and 6 months post-implant to assess medication review and actionable events



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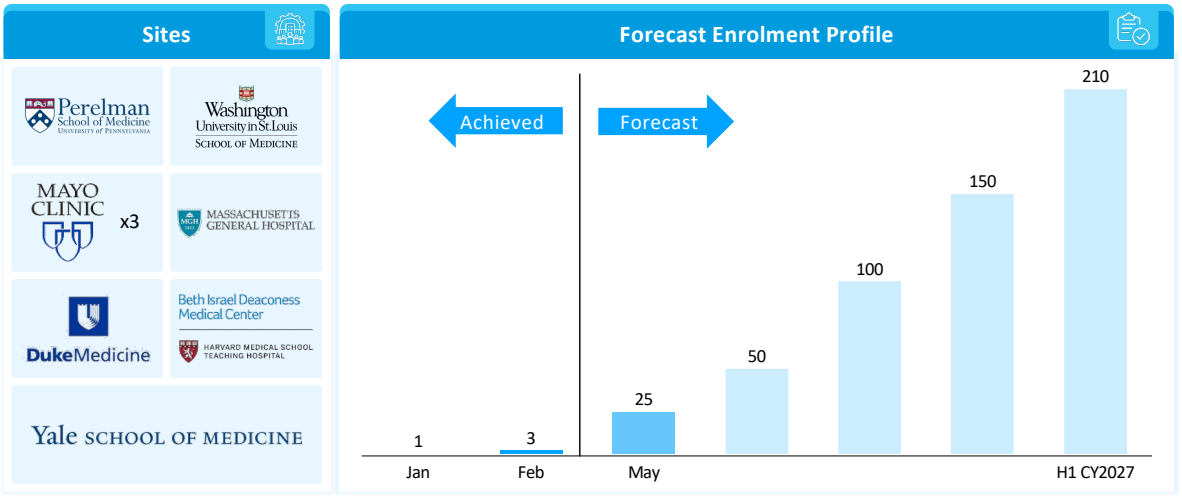
Detect reimbursement program.

The US has approximately 900 different payors including Federal (such as Medicare and VA), State, not for profit and for profit insures with various considerations for coverage. What they have in common is the need for Codes, Assigned Payment and coverage policy. Epiminder already has issued codes for the implantation of Minder and review of data that is generated. For 2026 Medicare reimbursement rate for implantation was increased to $27,700, a 23% increase from the initial proposed ruling. As the Minder device has FDA breakthrough designation it is also eligible for extra payments through Medicare's Transitional Pass Through (TPT) program for up to 3 years.

The Detect demonstration program intends to generate evidence to support payor coverage in the US. The study will implant 210 patients with Minder at up to 25 clinical sites. Its goal is to demonstrate the clinical utility of Minder data to Clinicians. We have made very good progress getting the study up and running.

The cost of the DETECT program is expected to be $25m over the next 24 months and is consistent with the Prospectus.

DETECT Enrolment progress



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We now have 9 US medical centers that are active sites, more than 1/3 of the total number of planned study sites. These centers represent premier institutions and key opinion leaders including Harvard, Yale, Mayo and UPenn. We expect a number more institutions to come online in the near future.

Our first implant was in January at UPenn. We now have 3 enrolled patients. I will note that a substantial winter storm across the US impeded patients from clinic visits from one to two weeks. Since the storm, sites are actively reviewing their patient pools, proposing study participation and scheduling visits. We anticipate that we will see the number of enrolled patients increase quickly and we will achieve 25 patients in the May timeframe. In terms of milestones, we would update the market when we attain 25, 50, 100, 150 and 210 pts in the study.

Clinician feedback

I am thrilled to be able to offer this innovative technology as we implant our first patient in the DETECT study. Standard EEG methods do not offer the long-term EEG monitoring necessary to make informed management decisions for many of our patients. The ability to provide continuous, high-fidelity monitoring over months and years bridges that critical diagnostic gap with far reaching implications for patients and providers. The long-term EEG data obtained is key in unlocking the future of epilepsy care, allowing us to achieving better outcomes and quality of life for our patients.

- Dr Taneeta Mindy Ganguly

Assistant Professor of Clinical Neurology

The Perelman School of Medicine at University of Pennsylvania

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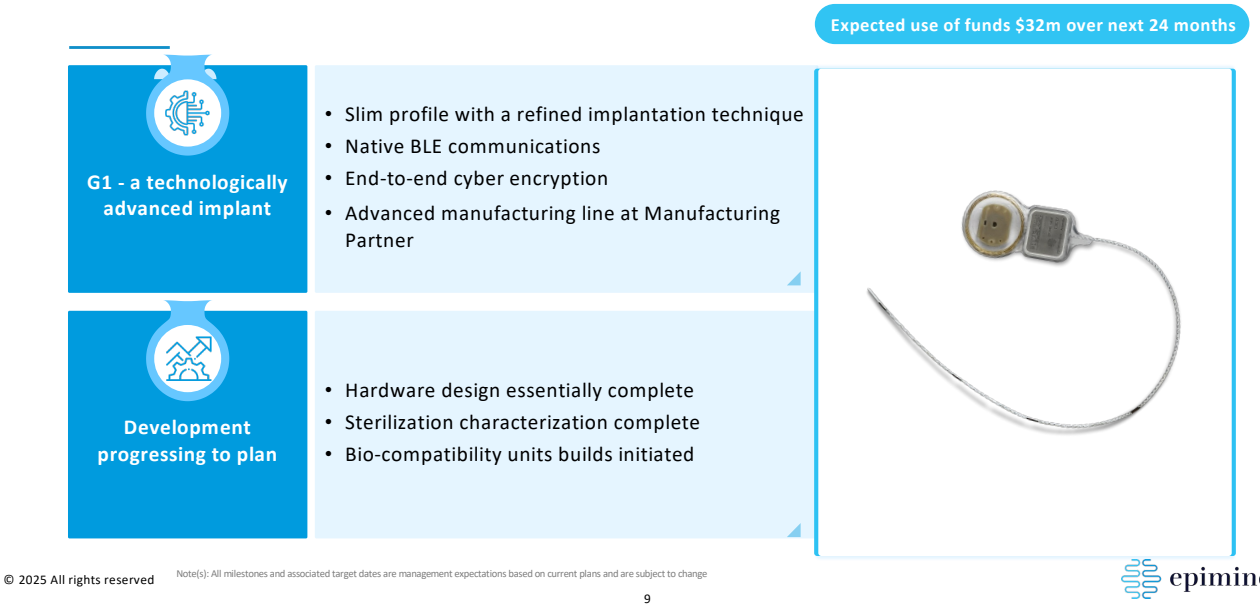
Clinicians are engaged and Principal Investigator at UPenn eloquently articulated the need for Minder which shows the excitement in the market around the potential benefits of accessing long term data via the Minder device.



Next generation device development

The next generation implant and cloud offering (G1) is a slim line implant that provides a refined implantation technique and incorporates numerous technologically advanced capabilities including end to end cyber encryption and native Bluetooth communication. This device will be built on the newest Cochlear manufacturing line and will benefit from lower device cost.

Development is proceeding to schedule, and development is expected to be completed at the end of H1 CY27. Hardware design is essentially complete, and implant manufacturing has commenced for extended biocompatibility testing. Initial device builds have been packaged and sterilized demonstrating that new design can be adopted into the existing sterilization cycle (process).

We anticipate FDA clearance in H2 CY2027 as previously stated.

We are also re-confirming the projected G1 spend that was disclosed in the Prospectus of $32m over the next 24 months.

Near term revenue opportunities

Ahead of its full commercial launch in H1 CY2028, Minder® has a number of opportunities to develop "proof points" of penetrating the market	
Pharmaceutical trials	• Epiminder is in discussions with multiple pharmaceutical companies regarding the use of Minder® in trials for new anti-seizure medications • Minder® could provide real time and accurate assessment of the novel ASMs undergoing clinical trials significantly reducing development costs and accelerating the time-to-market for promising new epilepsy therapeutics
Veterans Health Administration	• There is a large population of military veterans with epilepsy, due to the high prevalence of traumatic brain injury • The VHA allows treating healthcare professionals to make decisions about the clinical utility of FDA authorised devices for individual patients with lower thresholds of clinical evidence when compared to CMS and private payers • Epiminder is in discussions with physician members of the VHA Epilepsy Centers of Excellence regarding Minder®
US individual patient reimbursement	• Epiminder will work with Medicare, Medicaid and private payers to educate them on the Minder® system and the appropriate patient selection • Epiminder believes there is a reasonable prospect that the Minder® system may be approved on a case-by-case basis for patients who have failed to be adequately diagnosed or treated for epilepsy using current EEG modalities
Australian Special Access Scheme	• Australia operates an early access program, the Special Access Scheme (SAS) for devices not included in the Australian Register of Therapeutic Goods • Several neurologists have indicated to Epiminder that they are eager to apply for SAS coverage for Minder® given the lack of alternatives for continuous epilepsy monitoring

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Near term revenue opportunities.
While the immediate priority for the company is to get the DETECT clinical trial in full swing, over the next 2 years, we will seek to generate proof point of penetrating the market with Medicare, Veterans Affairs in the US, Pharma and in Australia with the Special Access Scheme. We are mapping out the pathway and requirements to access early revenue opportunities. We will provide more detail in subsequent updates.
I will now hand the call over to Mark to go through the financials.

1H FY26 Summary Financials

Profit & Loss

$000's	1H FY26	1H FY25	Variance %
Interest Income	**429**	**226**	**90%**
Employment Expenses	4,314	3,302	31%
DETECT Costs	474	630	-25%
R&D Costs (G1 + G0)	4,899	4,563	7%
Other Expenses	1,568	1,840	-15%
Operating expenses	**11,255**	**10,335**	**9%**
Share Based Payment Expenses	3,421	768	
Depreciation	18	52	
Impairment Loss	-	3,321	
FX gain or loss	77	(74)	
Other (including IPO Costs)	2,180	354	
Manufacturing Shares awarded to Cochlear	4,000	-	
Non-operating, Non Cash Expenses	**9,696**	**4,421**	**119%**
EBIT	**(20,951)**	**(14,756)**	**42%**
Interest Expense	**1,219**	**849**	**44%**
Net Income	**(21,741)**	**(15,379)**	**41%**

- Adjacent table is how we will report going forward: Opex and Non Opex.
- 2H FY26 opex expected to broadly double vs 1H FY26. 70% of cost increase driven by DETECT activity and ~25% by G1 investment.
- Non-operating, non-cash and one-off costs were $9.7m. Share based payments will be the main non-operating and non-cash P&L in 2H FY26 (~$3m for 2H).
- Interest expense eliminated after repayment of borrowing at IPO.

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The six months to 31 December 2025 have been a transformatory period for Epiminder following the IPO on 1 December which resulted in the Company raising $125m to significantly strengthen its capital base.

Slide 12 shows the P&L for the 6 months to 31 Dec 2025 compared to the prior corresponding period and this is the format we will be using going forward showing ongoing operating expenses split between employment expenses, DETECT costs, R&D costs and other expenses and also showing the non-operating and one-off costs that have also been incurred.

The opex cost base for the 1H was $11.3m with YoY growth of 9%. In the second half we expect this to double with 70% of the increase driven by DETECT spend and 25% driven by further R&D investment in G1.

For non-operating expenses, share based expenses increased in the first half due to options granted at IPO with the ongoing costs now around $3m every 6 months. The Company also incurred one-costs in relation to the IPO plus a $4m one-off charge in relation to issue of shares to Cochlear as part of the manufacturing collaboration, as disclosed in the Prospectus.

Balance Sheet

$000's	1H FY26	June FY25
Cash and Cash Equivalents	89,496	8,852
Prepayments, GST receivable	1,637	535
Current Assets	**91,133**	**9,387**
Fixed Assets	70	71
Intangible Assets	13,150	13,150
Non Current Assets	**13,220**	**13,221**
Assets	**104,353**	**22,608**
Accounts Payable	1,714	1,701
Accruals	1,408	17,199
Employee Benefits	804	577
Borrowings	-	8,380
Current Liabilities	**3,926**	**27,857**
Debenture Notes	-	48,000
Long Service Leave Provision	157	110
Non Current Liabilities	**157**	**48,110**
Liabilities	**4,083**	**75,967**
NET ASSETS	**100,270**	**(53,359)**
Share Capital	209,141	37,224
Retained Earnings	(119,993)	(98,252)
Options Reserve	11,122	7,669
Equity	**100,270**	**(53,359)**

- Strong balance sheet post IPO
- Cash at 31 December 2025 was $89.5m
- No debt

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Epiminder's IPO capital raise has delivered a strong and clean balance sheet. At end of December, we had $89.5m of cash with no debt.

Cash Flow

$000's	1H FY26	1H FY25
Interest Receivable and Receipts	429	5,908
DETECT Costs	(308)	(658)
G1 Costs	(4,886)	(4,483)
Staff Costs	(4,360)	(3,740)
ATO Refund	(15,766)	-
Other Costs	(4,470)	(1,561)
Operating Activities	**(29,362)**	**(4,535)**
Payment for property, plant and equipment	(10)	(17)
Investing Activities	**(10)**	**(17)**
Other cash items from financing activities	109,984	3,259
Financing Activities	**109,984**	**3,259**
Net Cash Flow	**80,612**	**(1,293)**
Cash and cash equivalents at beginning of period	8,852	11,313
Net change in cash for period	80,612	(1,293)
Effect of exchange rate changes on cash	32	(31)
Cash and cash equivalents at end of period	**89,496**	**9,988**

- Cash position and cash forecast has improved compared to prospectus driven by ATO refund being $4.2m lower than previous disclosure plus tailwind from FX since IPO.
- 1H FY26 cashflow impacted by several one-off items including ATO refund and capital raising costs.
- Cash at 31 December 2025 was $89.5m
- Cash burn in 2H FY26 expected to be around $20m due to DETECT ramp up and G1.

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The company's cash position and cash flow forecast have improved compared to the prospectus driven by ongoing prudent cost management, the ATO refund which was $4.2m lower than forecast plus the FX tailwind since the IPO driven by the weakening US dollar versus the Australian dollar.

The first half cashflow had a number of significant one-off items impacting the normal operating cashflow including the ATO refund, the IPO related costs and of course the $110m proceeds from the IPO net of fees and $6m of interest paid on convertible notes. These items were all highlighted in our prospectus.

Importantly we start 2026 with around $90m of cash resources to fund the commercialization plan that Rohan has outlined and we expect the cash burn in the second half of FY26 to be around $20m.

FY26 Outlook

Progression on DETECT and development of the G1 Minder device is the priority.

For 2H FY26, Epiminder expects a net cash outflow of approximately $20m with the variability driven by the timing of DETECT centre sign up and patient implant volumes. If more Minder implants occur, the cash burn will be higher.

Epiminder forecasts it has sufficient cash reserves to complete DETECT and the next generation Minder® device (G1) as planned and fund business operations well into CY28

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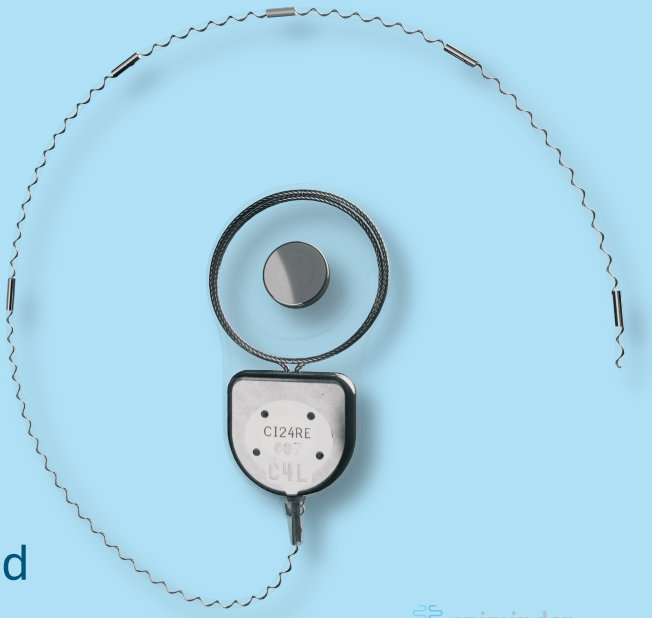
Looking forward to the second half, DETECT and G1 remain the priority focus for the Company.

We expect to consume approximately $20m of our cash reserves based on our current forecast for implants under the DETECT program. The higher the number of implants though, which would be a good sign, the higher the cash burn.

We are also confirming that Epiminder has sufficient cash reserves to complete its two key priorities, DETECT and FDA authorization of our next gen Minder devices and fund the company well into CY28.

Appendix:
Company Background

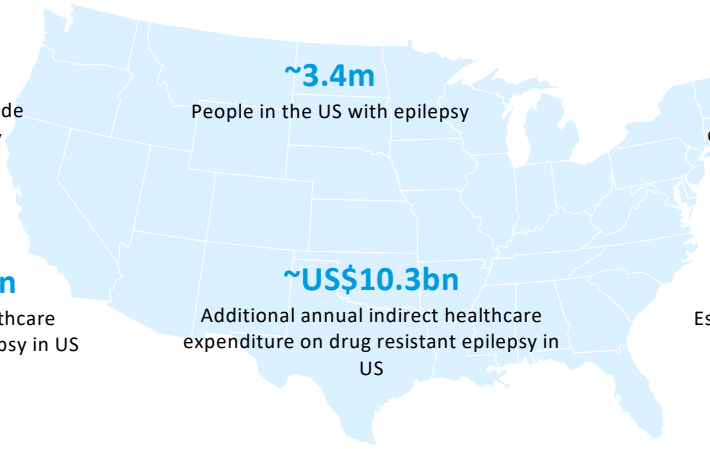


Epilepsy overview: The unmet need and economic burden

~52m
People worldwide with epilepsy

~3.4m
People in the US with epilepsy

~1.1m
Adults in the US with drug resistant epilepsy



~US$28bn
Direct annual healthcare expenditure on epilepsy in US

~US$10.3bn
Additional annual indirect healthcare expenditure on drug resistant epilepsy in US

~US$1.1bn
Estimated annual target market*

Sources: F&S Market Report

* Based on Annual 25,000 to 45,000 drug resistant adult patients with inconclusive Comprehensive Epilepsy Center visits to which the Minder device could support treatment. Average Selling price assumed to be US$25,000

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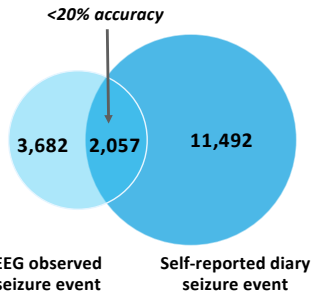
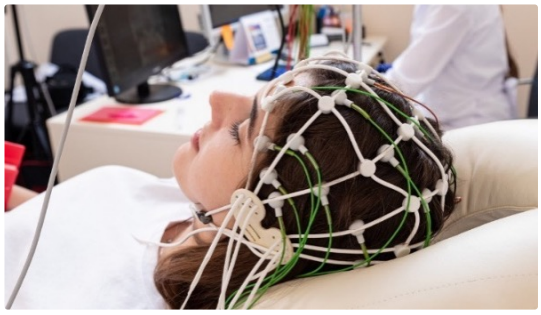
Current technologies and techniques

Current technologies and techniques have significant limitations – these shortcomings may result in diagnosis delays, misdiagnosis, ineffective and in some cases inappropriate treatment

Patient diaries remain the only option for long-term monitoring, but they are highly inaccurate[1]



Epilepsy Monitoring Unit EEGs are expensive and disruptive to patients, while 30 – 50% of assessments are inconclusive[2]



Note(s): (1) Adapted from Hannon et al Epilepsia 2024, DOI: 10.111/epi.17930; N = 17,231 events from 3,407 patients; (2) F&S Market Report

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Minder® is an integrated hardware and software system

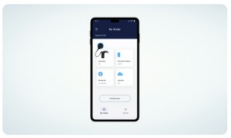
The Minder® System

Minder® Implant

Comprises a sub-scalp electrode lead with multiple recording points that captures stable, long-term EEG signals continuously for months or years. These electrodes are connected to an impacted telemetry unit that wirelessly transmits the recorded brain activity through the skin to the external Minder® Wearable device.

Minder® Wearable

The Minder® Wearable receives and stores EEG recordings wirelessly transmitted from the Minder® Implant, then transfers this data to the Minder® App, running on a smartphone. It is powered by a rechargeable battery.



Minder® App

The Minder® App collects and transmits EEG data from the Minder® Implant via Bluetooth and uploads it to Minder® Cloud for processing. It can also record entries for a patient's seizure diary.

Minder® Cloud

Minder® Cloud offers a secure online portal that allows healthcare professionals to access and download patient data for viewing.

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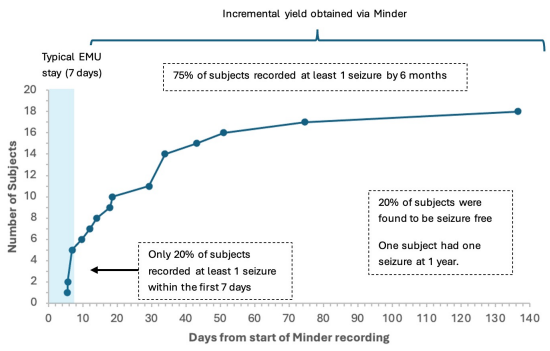
Minder® provides actionable data over an extended monitoring window

Minder® monitoring: Seizures captured over time[1]



UMPIRE[1] clinical study

Minder® delivered meaningful and actionable clinical insight for ~88% of patients

Examples of real observable outcomes

- ✓ Surgical resection cancelled, patient has been implanted with Vagus Nerve Stimulation (VNS)
- ✓ Medications were gradually withdrawn, with no ongoing seizures and able to drive again
- ✓ Patient now being evaluated for surgical resection
- ✓ Pacemaker implanted which treated cardiac condition, ASM reduced by 50%, and patient seizure free

Note(s): (1) Epiminder UMPIRE study

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