INVESTOR PRESENTATION

ASX:IPD OCTOBER 2020

impedimed®

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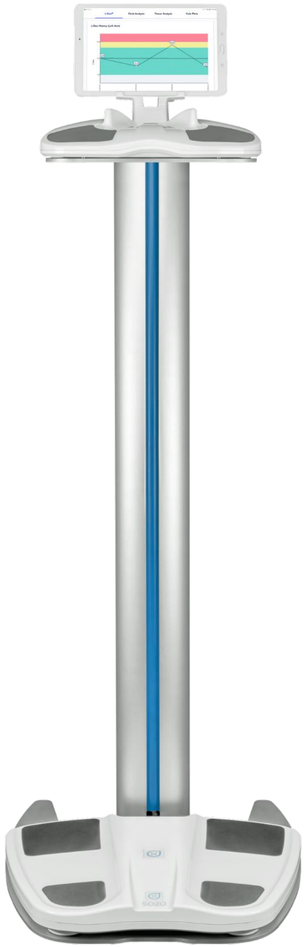
Investment Highlights

- Highly Disruptive Technology
- Proprietary Digital Health Platform with Robust Patent Portfolio
- Large and Growing Markets
- Regulatory Clearances FDA, CE Mark & ARTG
- Significant Body of Clinical Evidence
- SaaS Model well Established with CRP* of A$13.1m at 30 Sept. 2020
- Annual Recurring Revenue* of A$6.0m at 30 September 2020



SOZO Digital Platform
1 Device, Multiple Applications

- Lymphoedema FDA, CE Mark
- Heart Failure FDA, CE Mark
- End Stage Renal Disease** CE Mark
- Protein Calorie Malnutrition FDA, CE Mark
- Body Composition FDA, CE Mark
- Bone Density^
- Venus Insufficiency^^

* Refer to Appendix for a Glossary of terms used

** kidneyfund.org: Kidney failure is the last and most severe stage of chronic kidney disease and is also referred to as End-Stage Renal Disease (ESRD)

^ Algorithm has been developed and preliminary discussions have been held with FDA

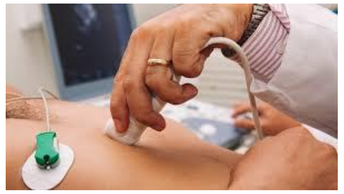
^^ Proof of concept studies undertaken; no regulatory applications submitted to date

ImpediMed's Proprietary Technology Directly Measures Fluid in the Body

Using Bioimpedance Spectroscopy (BIS), SOZO non-invasively measures, monitors and manages fluid status and tissue composition

Inferred Measures of Fluid

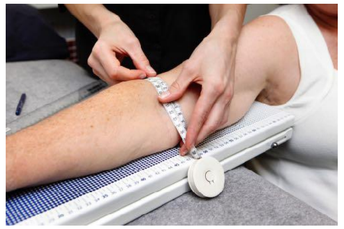
- Imaging



- Implantables

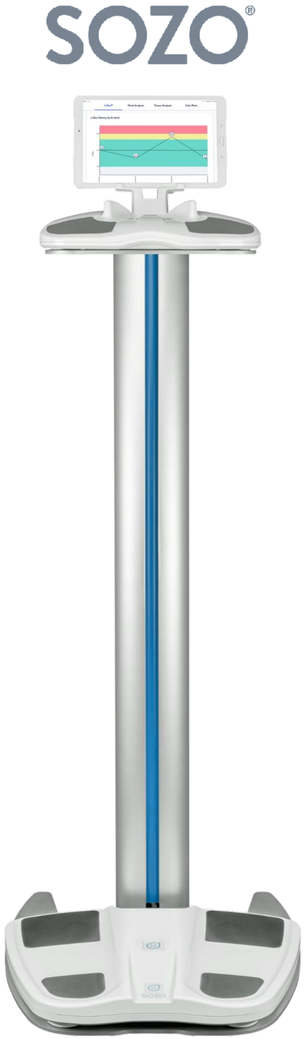
- Weight

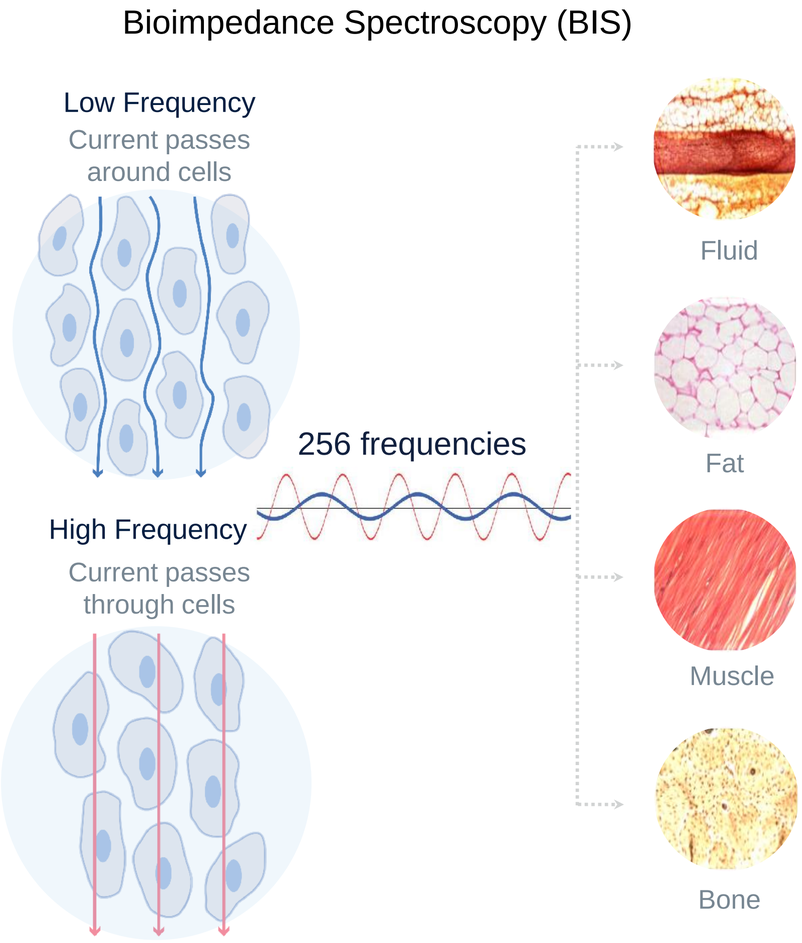
- Volume



- Observation

SOZO Directly Measures Fluid





Connected Digital Health Platform

Connected Digital Health Platform

- Comprehensive patient data (HIPAA compliant)
- Access to information across the care continuum
- Manage large patient populations
- Integrates seamlessly into hospital, clinical, and home settings
- Growing database of patient measurements
- Data is already driving:
  - Increased accuracy
  - Automated protocols
  - Real world clinical data to support FDA filings

Key Centres

Vanderbilt University Medical Center

Macquarie University

Mayo Clinic Cancer Center

Cleveland Clinic

The University of Texas MD Anderson Cancer Center

City of Hope

KU Medical Center – The University of Kansas

UPMC – University of Pittsburgh Medical Center

Sharp – San Diego's Health Care Leader

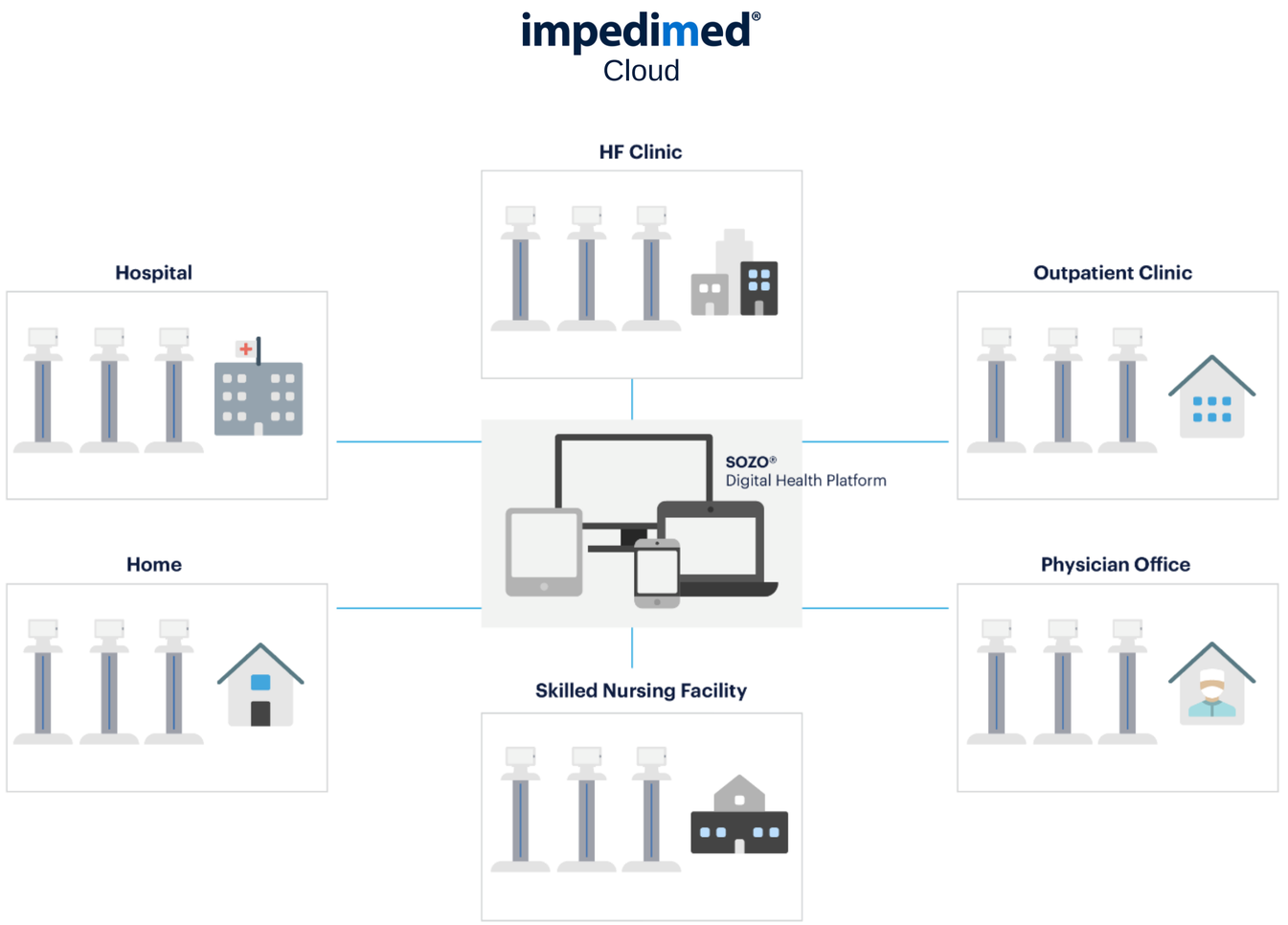
Montefiore Health System

The Ohio State University Wexner Medical Center

University Hospitals

Connected Digital Healthcare Platform Allows Data Access and Sharing

Test Patients at Any Location and Share Information Across the Entire Healthcare System



Access

Test patients at any location and immediately review results online

Trends

Track trends in patient data for actionable results

Scalable

Add and move test locations without any additional software setup

Secure

Control who accesses the SOZO network and establish unique security settings

Initial Focus on Three Large and Growing Markets

Oncology

Lymphoedema
Protein Calorie Malnutrition^
Dehydration

A$1+ billion

Heart Failure

Fluid Overload
Protein Calorie Malnutrition^

A$700+ million

Renal Failure

Fluid Overload
Protein Energy Wasting^

A$300+ million

$2.0+ Billion

Annual Addressable Market

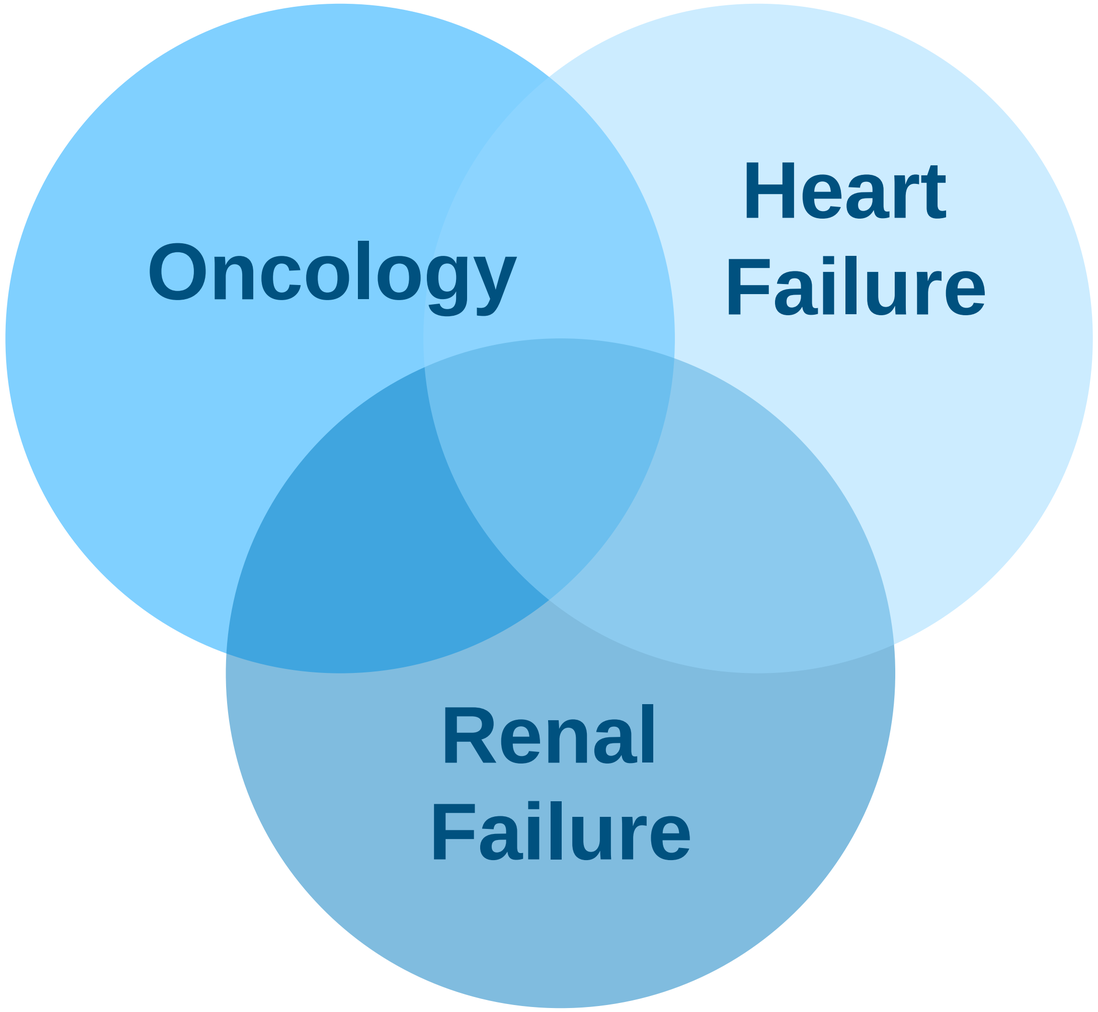
^In Renal Failure, the terms Protein Calorie Malnutrition (PCM) and Protein Energy Wasting are often used interchangeably. ImpediMed most commonly refers to this disease state as PCM

Markets with Significant Opportunities

	Oncology Lymphoedema Protein Calorie Malnutrition Dehydration	**Heart Failure** Fluid Overload	**Renal Failure** Fluid Overload Protein Calorie Malnutrition
Chronic disease	✓	✓	✓
Long-term patient management	✓	✓	✓
High cost of care	✓	✓	✓
Large unmet need	✓	✓	✓

Markets Significantly Overlap

- Cardiovascular disease is the leading cause of death among people on dialysis with kidney disease
- Dialysis patients experience high rates of mortality, driven largely by an exceptionally high rate of cardiovascular related mortality, which exceeds that of the general population by 10 to 20-fold
- It is common for people with chronic kidney disease or end stage renal failure to develop heart disease
- Heart failure leads to a 11.4x greater risk for end stage renal failure
- Protein calorie malnutrition or protein energy wasting is common in patients with chronic kidney disease and is one of the strongest predictors of patient mortality
- Cardiovascular disease is the predominant cause of death in breast cancer patients aged over 50
- The risk of death from heart disease in cancer patients is 2.24x that of the general population
- Protein calorie malnutrition is the most common secondary diagnosis in cancer patients affecting more than 50% of patients with certain cancers



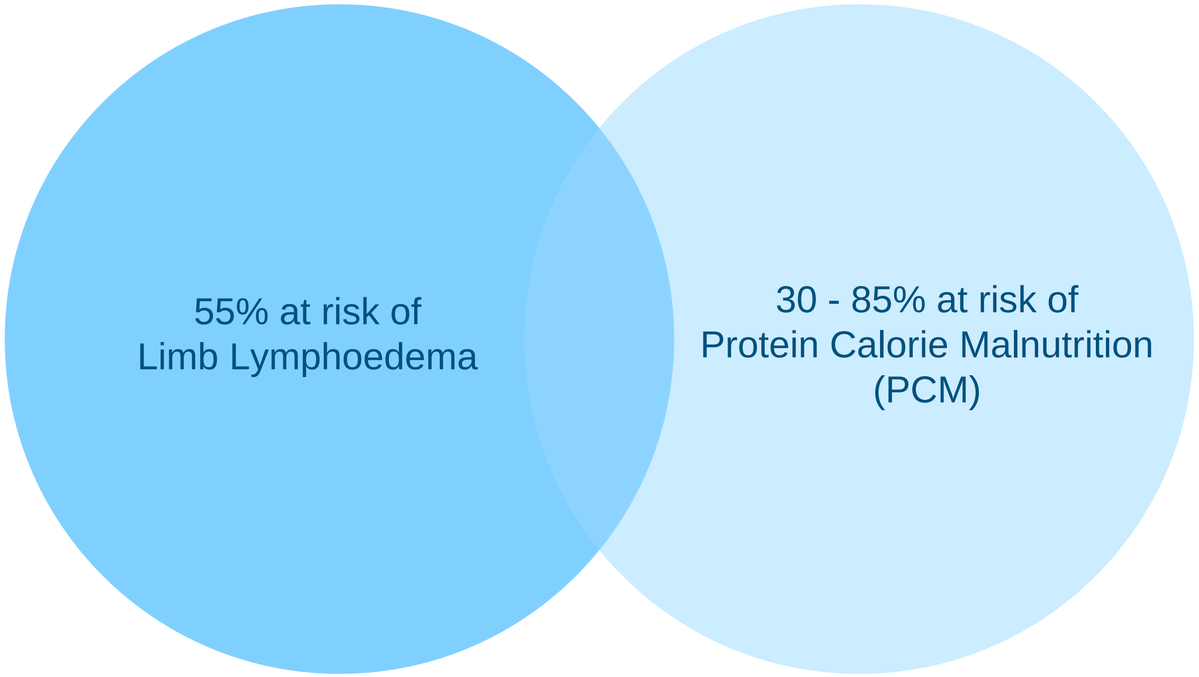
ONCOLOGY

Oncology

Lymphoedema

Protein Calorie Malnutrition

Newly Diagnosed Cancer Cases
1.8 Million per Year



$1.4 Billion

Annual Addressable Market[1]

1 Assumes: 17 lymphoedema tests as per Lymphoedema Prevention Program protocol and 7 PCM checks at $50

- Currently 1 in 3 at risk cancer survivors will develop secondary lymphoedema
- Lymphoedema costing the US healthcare system ~$7 billion annually
- ImpediMed's PREVENT trial showed a 95% reduction in lymphoedema progression at one year
- Recent NCCN Guidelines® changes stated: "Early detection/diagnosis of lymphedema is key for optimal Management"
- Protein Calorie Malnutrition is the most common secondary diagnosis in cancer patients, affecting more than 50% of patients with certain cancers
- 1 in 3 hospitalised patients are at risk of PCM
- ImpediMed is the first and only company with an FDA Clearance for PCM

Lymphoedema is a Real and Growing Problem

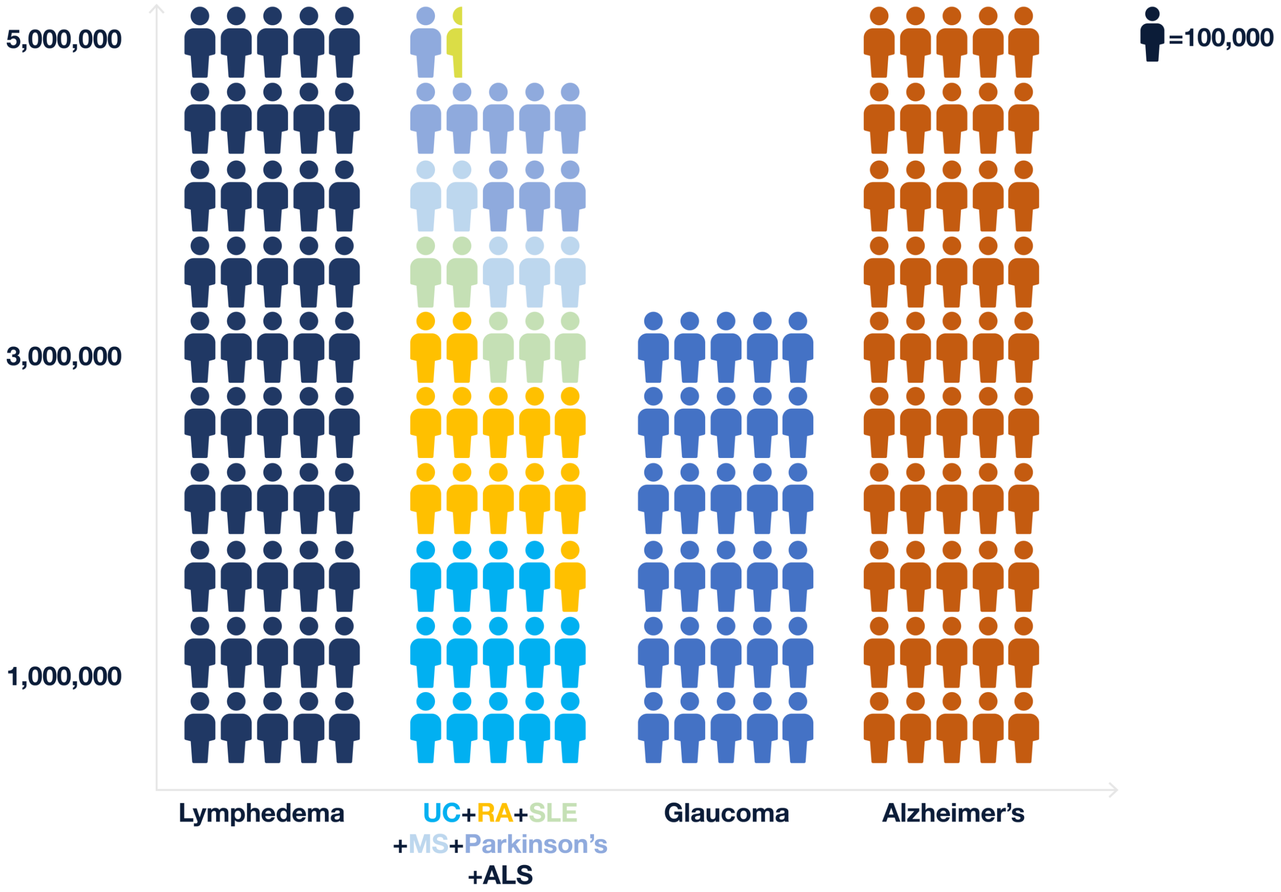
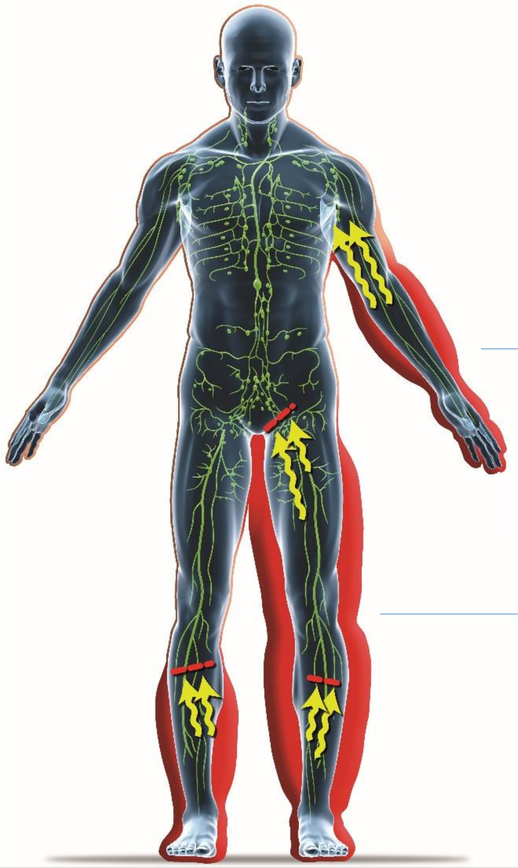


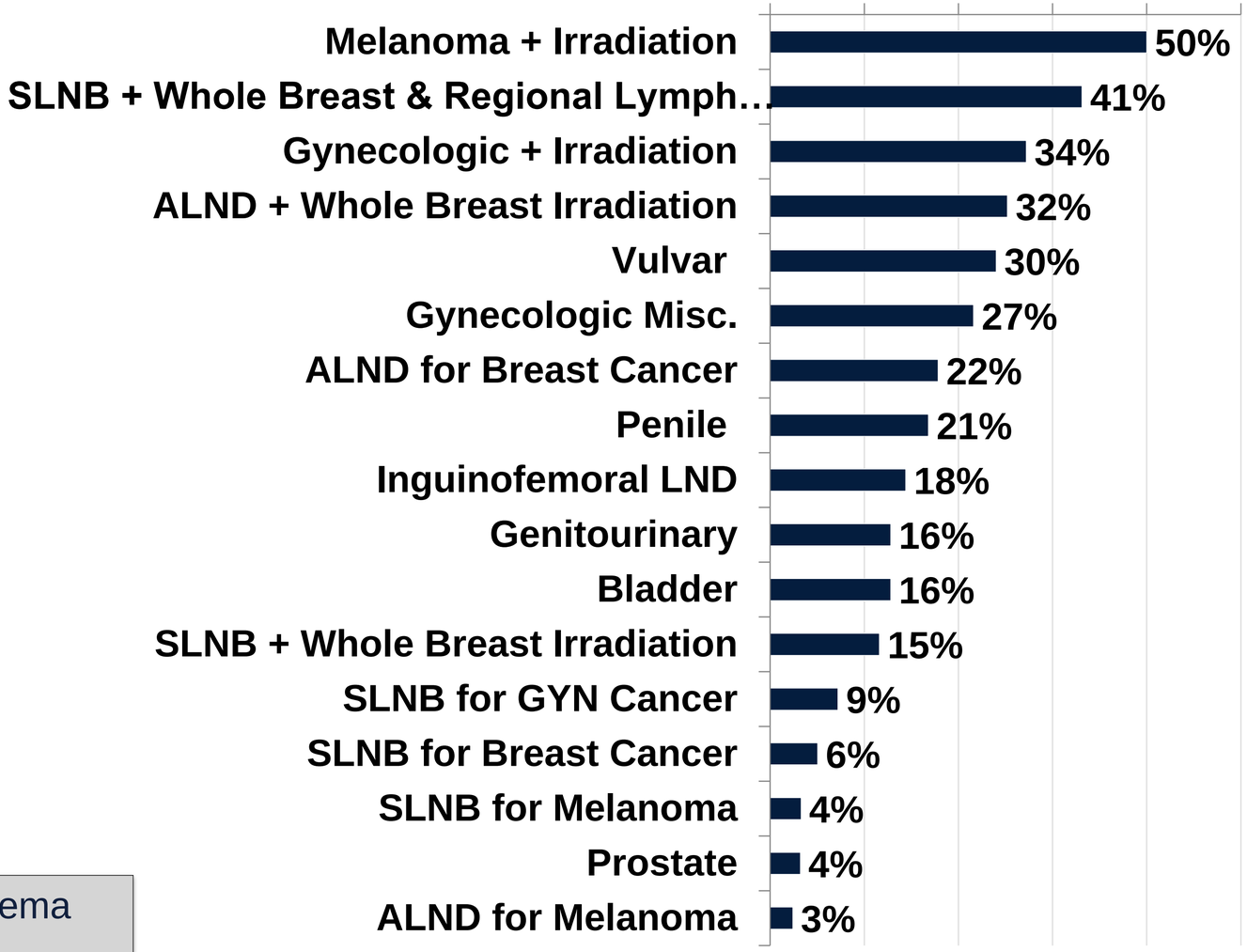
Fig 2. Number of patients in the United States who suffer from lymphedema versus other common chronic disorders.
UC, ulcerative colitis; RA, rheumatoid arthritis; SLE, systemic lupus erythematosus; MS, multiple sclerosis; amyotrophic lateral sclerosis.

- Over 15.5 Million cancer survivors in the U.S.
- 1 in 3 will develop Lymphoedema
- More than 5.5 Million U.S. patients suffering from persistent cancer-related Lymphoedema
- Lymphoedema usually presents within first 36 months
- Lymphoedema is one of the most feared consequences of cancer survivorship

Lymphoedema Does Not Just Affect Breast Cancer Survivors

Prevalence by Cancer and Treatment





Today, 1 in 3 Cancer Survivors will Develop Lymphoedema
“It does not have to be this way”

Modified - Shaitelman, S.F., et al., *Recent progress in the treatment and prevention of cancer-related Lymphoedema .* CA Cancer J Clin, 2014

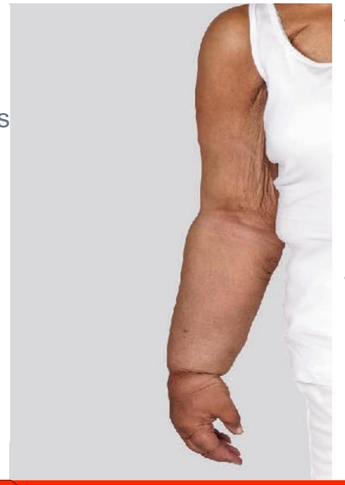
Current State of Lymphoedema Detection and Treatment

Stages

- Transport capacity is reduced, setting the stage for an overload of the lymphatic system
- Readily reversible and easily treatable

- Accumulation of fluid and protein causing swelling; pitting oedema may be evident
- Symptoms may be reduced with intensive intervention

- Spongy tissue consistency, tissue fibrosis causing hardness and increase in size
- Irreversible. Lifelong treatment of symptoms



- The affected limb becomes very large and misshapen, and the skin takes on a leathery appearance
- Irreversible. Lifelong treatment of symptoms

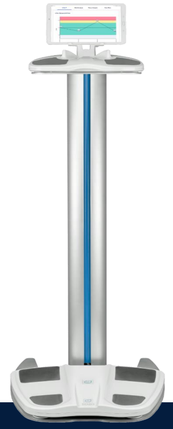
STAGE 0 - Not Visible
Subclinical

STAGE 1 - Pitting Oedema
Clinical

STAGE 2 - Irreversible
Clinical

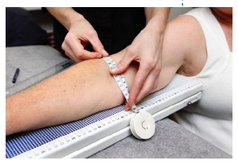
STAGE 3 - Elephantiasis
Clinical

Detection

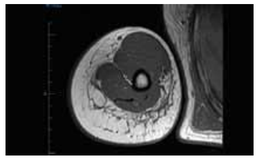


Only L-Dex detects subclinical Lymphoedema

Perometry (Optical Scanner)



Tape Measure

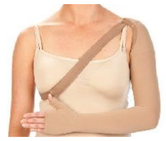


Imaging

Treatment

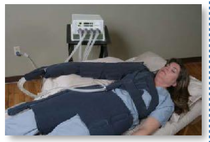
Complex Decongestive Physiotherapy

Wrapping



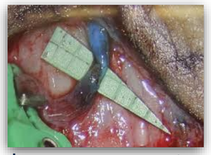
Custom Sleeves

Hospitalisations & Antibiotics



Pneumatic Pumps

Lymph Node Transfer



Lymphovenous anastomosis

Liposuction

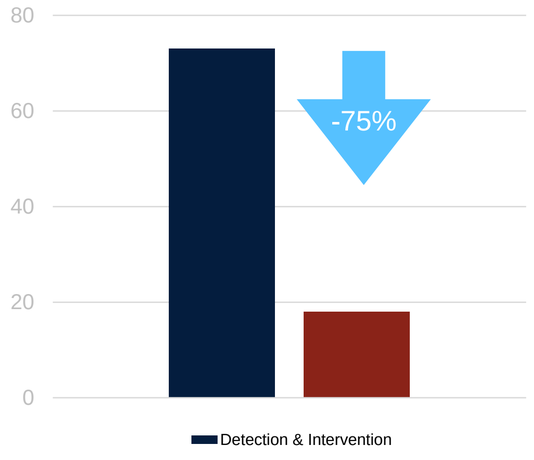
$7 Billion Annual Cost

1. ISL, *The diagnosis and treatment of peripheral Lymphedema : 2013 Consensus Document of the International Society of Lymphology.* Lymphology, 2013. 46(1): p. 1-11
2. NCCN Survivorship Guidelines Version 1.2109

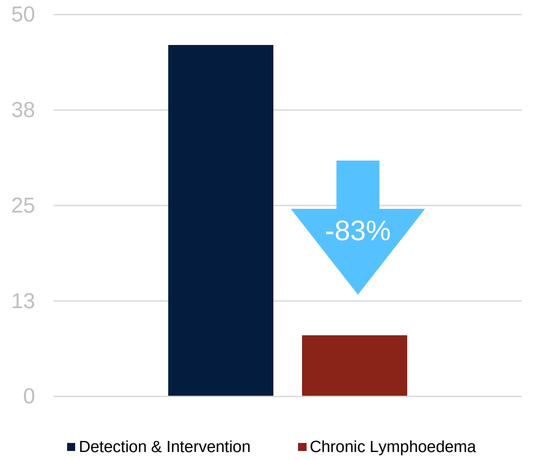
Demonstrated Real World Outcomes in Breast Cancer Related Lymphoedema

- Compelling clinical data
- Medically meaningful results
- Effectively implemented across a broad spectrum of practices - from large teaching Cancer Centres to single practitioners
- L-Dex proved effective in reducing cancer related Lymphoedema in both high and low risk patients
- To-date >140 peer reviewed Lymphoedema studies published involving >17,000 patients

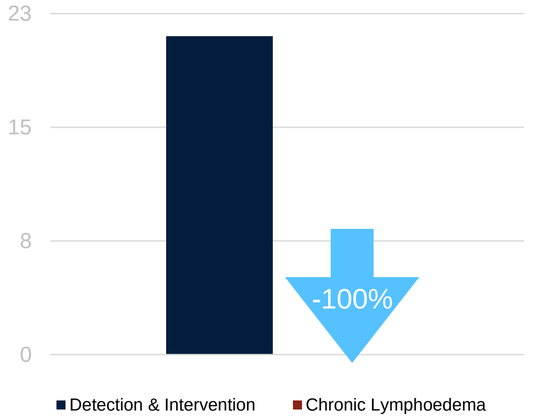
Nashville Breast Center, TN, USA
(n=596, F/U 17 months)



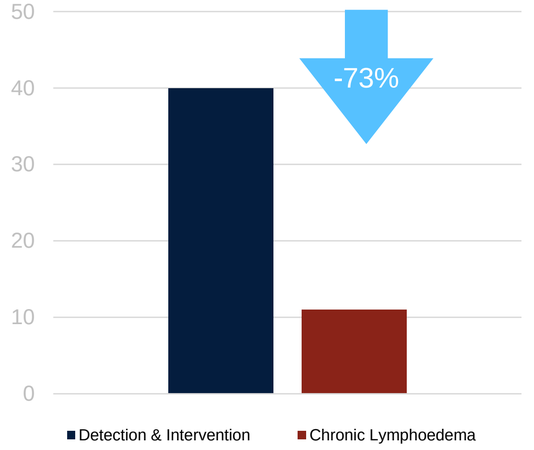
Macquarie University, NSW, AUS
(n=188, F/U 8 months)



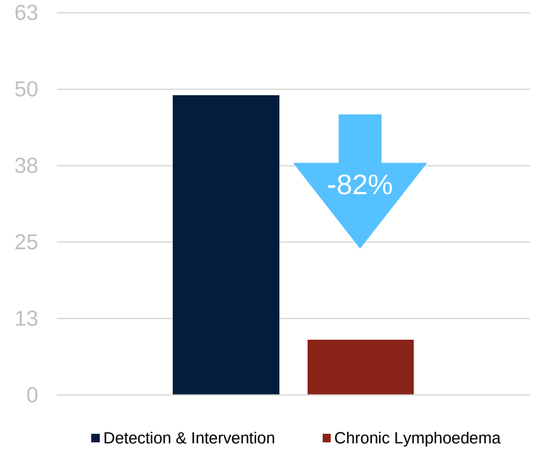
Breast Care Specialists, NY, USA
(n=206, F/U 25.9 months)



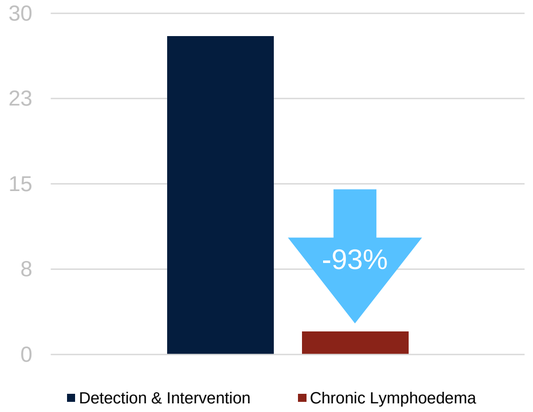
Texas Breast Specialists & N. Texas Surgical Oncology Assoc, TX, USA
(n=326, F/U 21.7 months)



University of Kansas Cancer Center, KS, USA
(n=146, F/U 21 months)



University of Pittsburgh Medical Center, PA, USA
(n=186, F/U 20 months)



Practice-Changing Results – PREVENT Trial Interim Results

Primary Aim

- Does early detection and intervention with BIS reduce need for BCRL treatment with CDP vs. circumference measurements

Summary and Results

- International, Multi-Institutional Randomised Controlled Trial
  - Planned enrolment 1,100 patients, 10 medical centres across the United States and Australia
  - 3 Year follow-up (ends 31 December, 2020)
- Randomised to L-Dex vs. Volume measurements (circumference)
  - L-Dex: Trigger ≥ 6.5
  - Volume: Trigger 5-10%
- Results 41 patients triggered an intervention
  - L-Dex: 2 progressed (4.9%)
  - 68 patients triggered an intervention
  - Volume: 10 progressed (14.7%)
  - Relative difference 67% (primary endpoint 20%)

95% reduction

Conclusions

- "These preliminary results are important and support the use of subclinical detection with BIS and early intervention for patients with breast cancer at risk for lymphedema".
- "If current rates remain consistent, it is expected that with the greater number of events, the difference between BIS and TM will become statistically significant."
- "Further data with a longer follow-up than in this study is expected in the years to come and will strengthen these early, positive, practice-changing results".

12 Month Interim Results Publication:
Annals of Surgical Oncology
May 3, 2019

Ann Surg Oncol
https://doi.org/10.1245/s10434-019-07344-5

Annals of SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ORIGINAL ARTICLE – BREAST ONCOLOGY

A Randomized Trial Evaluating Bioimpedance Spectroscopy Versus Tape Measurement for the Prevention of Lymphedema Following Treatment for Breast Cancer: Interim Analysis

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ABSTRACT

Background. Breast cancer-related lymphedema (BCRL) represents a major source of morbidity among breast cancer survivors. Increasing data support early detection of subclinical BCRL followed by early intervention. A randomized controlled trial is being conducted comparing lymphedema progression rates using volume measurements calculated from the circumference using a tape measure (TM) or bioimpedance spectroscopy (BIS).

Methods. Patients were enrolled and randomized to either TM or BIS surveillance. Patients requiring early intervention were prescribed a compression sleeve and gauntlet for 4 weeks and then re-evaluated. The primary endpoint of the trial was the rate of progression to clinical lymphedema requiring complex decongestive physiotherapy (CDP), with progression defined as a TM volume change in the at-risk arm ≥ 10% above the presurgical baseline. This prespecified interim analysis was performed when at least 500 trial participants had ≥ 12 months of follow-up.

Results. A total of 508 patients were included in this analysis, with 109 (21.9%) patients triggering prethreshold interventions. Compared with TM, BIS had a lower rate of trigger (15.8% vs. 28.5%, $p < 0.001$) and longer times to trigger (9.5 vs. 2.8 months, $p = 0.002$). Twelve triggering patients progressed to CDP (10 in the TM group [14.7%] and 2 in the BIS group [4.9%]), representing a 67% relative reduction and a 9.8% absolute reduction ($p = 0.130$).

Conclusions. Interim results demonstrated that post-treatment surveillance with BIS reduced the absolute rates of progression of BCRL requiring CDP by approximately 10%, a clinically meaningful improvement. These results support the concept of post-treatment surveillance with BIS to detect subclinical BCRL and initiate early intervention.

This research was presented at the Scientific Oral Presentation Session of the 20th Annual Meeting of the American Society of Breast Surgeons, Dallax, TX, USA, on 3 May 2019.

First Received: 11 October 2018

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Published online: 03 May 2019

Reimbursement is the Key to Accelerating Lymphoedema Revenues

NCCN Guidelines®

- Joint application by Vanderbilt, LE&RN and the American Society of Breast Surgeons Foundation led to the following outcomes:
  - Inclusion into Breast Cancer Guidelines
  - Preoperative Baseline measurements
  - Early detection/diagnosis of lymphoedema is key for optimal management
- Upon publication of the Meta-Analysis, the Company will apply for guidelines changes to establish formal testing protocols and inclusion of L-Dex as an objective measurement tool

Commercial Payors

- Discussions ongoing with National and Regional payors
- Retained MCRA - reimbursement specialist
- Actively pursuing reimbursement outcomes
- Policy alignment with all 10 Medicare Administrative Contractors
- David Anderson recently joined the Board:
  - David is President and CEO of HealthNow Systems, Inc., operating as BlueCross BlueShield of New York
  - BlueCross BlueShield provides healthcare services to 1 in 3 Americans

Level 1 Evidence

- The Meta-Analysis has been accepted and is currently pending publication this quarter
- PREVENT Trial finishes December 2020 and will read out in Q1 CY2021
- Remain confident the PREVENT trial will reach statistical significance

Oncology - Key Takeaways and Next Steps

Key Takeaways

Lymphoedema is a real and growing problem

- Over 15.5 Million cancer survivors in the U.S.
- 1 in 3 will develop Lymphoedema
- More than 5.5 Million U.S. patients suffering from persistent cancer-related Lymphoedema

Significant body of evidence supporting L-Dex

- Compelling clinical data and medically meaningful results
- To-date >140 peer reviewed Lymphoedema studies published involving >17,000 patients

SOZO has the potential to:

- Significantly reduce the incidence of Lymphoedema
- Simultaneously track patients for both Lymphoedema and Protein Calorie Malnutrition
- Become standard of care for Lymphoedema

Next Steps

Further supporting evidence for Private Payors and NCCN

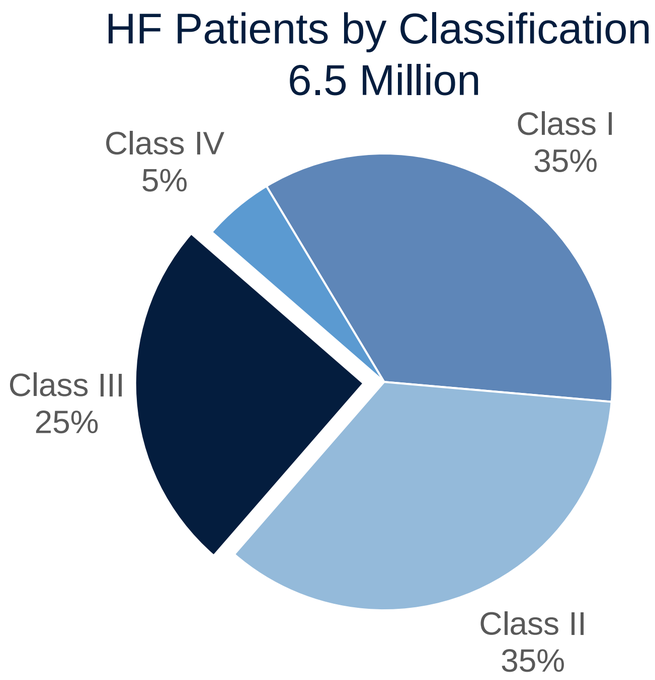
- Level 1 evidence for Private Payors and NCCN
  - The Meta-Analysis has been accepted and is currently pending publication in the coming weeks
  - PREVENT Trial finishes December 2020 and will read out in Q1 CY2021
- Publication of an additional scientific paper assessing the risk of subclinical Lymphoedema by the extent of surgery and radiation

Continued strong growth in SOZO SaaS subscription-based business

- Growth will accelerate as Private Payors begin coverage of L-Dex
- NCCN Guidelines® — Applications for the addition of a formal testing protocol and inclusion of L-Dex. If accepted L-Dex will become standard of care

HEART FAILURE

Heart Failure – A Significant Healthcare Issue



$700+ Million

Annual Addressable Market[1]

- Global pandemic affecting at least 26 Million people worldwide
- HF costs US healthcare system estimated $31 billion annually
- Estimated 6.5 Million Americans live with heart failure
- 1 in 5 over the age of 40 will develop heart failure
- Most common cause of hospitalisation of people 65 years and older
- About half of people who develop heart failure die within five years of diagnosis
- After a single heart failure hospitalisation:
  - Above 20% of patients are readmitted within 30 days
  - Nearly 50% are readmitted in six months
- Clear path to reimbursement
- SOZO technology adopted by AstraZeneca to measure fluid outcomes in heart failure patients with chronic kidney disease

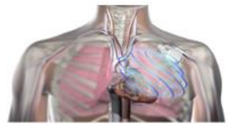
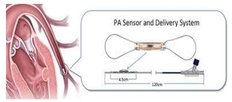
1 Assumes: Hospital and follow-up testing at $30 per test with home testing for class III and IV patients for 30 days at $15 per day

Heart Failure is a Significant Healthcare Issue and Current Monitoring Methods are Inadequate

Fluid and Heart Failure

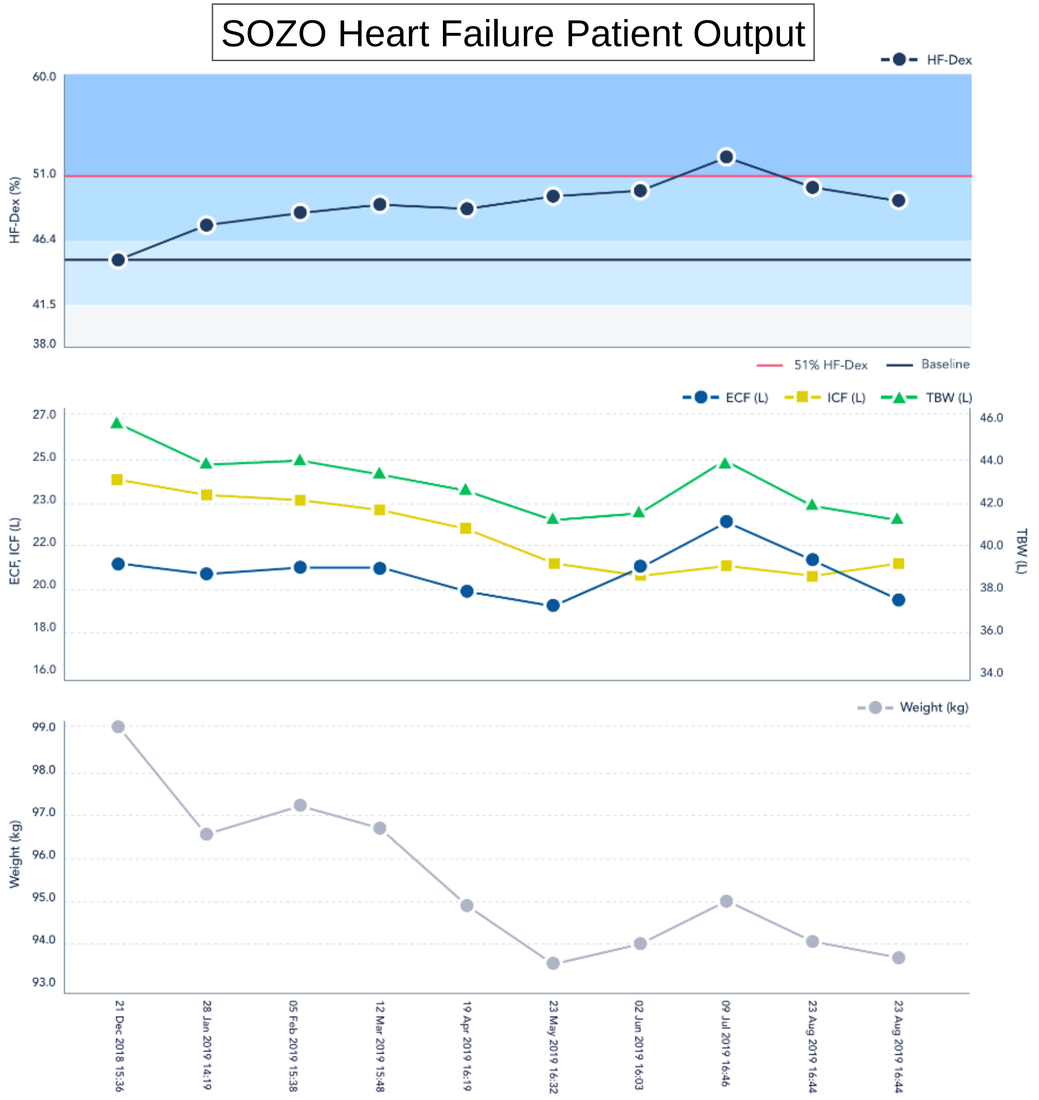
- Assessment of fluid burden is critical to the management of heart failure patients
- Current methods of determining fluid levels are either inaccurate or invasive and expensive
- Evaluation and optimisation of volume status is an essential component of treatment in patients with heart failure
- Removal of excess extracellular fluid with diuretics is one of the mainstays of volume management and for the majority of patients with heart failure, diuretics are essential for the control of volume status
- Ongoing detection of fluid build up is critical to reducing hospital readmissions

Current Monitoring Methods

	Device	Method	Benefit	Shortcomings
Weight Scale		**Rapid weight gain**	**Low cost**	**Inaccurate and rudimentary**
Implantable Leads		**Intrathoracic Impedance**	**Detects HF in time for intervention**	**Invasive, limited availability, poor data output**
CardioMEMS		**PA waveforms**	**Detects HF in time for intervention**	**Invasive and expensive**

HF-Dex™ Fluid Analysis for Heart Failure

- Announced a new software release that includes the HF-Dex™ heart failure assessment for the SOZO Digital Health Platform. The new software also includes an assessment for patients with end stage renal disease (ESRD) as well as usability and data management improvements
- HF-Dex heart failure index
  - Indicator of patient fluid overload
  - Defined as ECF as a percent of TBW
- Objective measure of fluid volume
  - Accounts for fluid and tissue-related weight changes
  - Tracks response to medications
  - HF-Dex >51% a marker of readmission



Heart Failure - Key Takeaways and Next Steps

Key Takeaways

- Global pandemic affecting at least 26 million people worldwide and costing US healthcare system estimated $31 billion annually
- Estimated 6.5 Million Americans live with heart failure
- There is currently no way to objectively and accurately measure fluid, a key determinate of heart failure
- SOZO has the potential to:
  - Allow clinicians to determine fluid overload with a single test and track medically meaningful fluid changes over time
  - Track and assess the effectiveness of dosage changes
  - Significantly reduce costs associated with managing HF patients

Next Steps

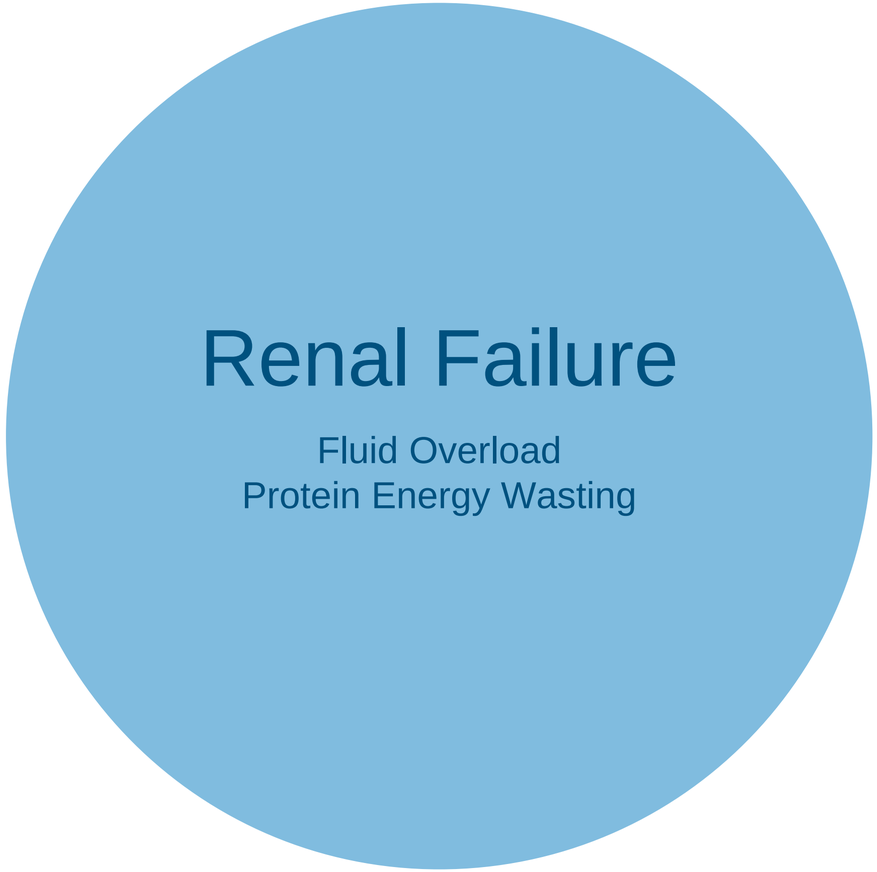
- First commercial sales
- Obtain real world evidence
  - To demonstrate that SOZO can track fluid patient fluid levels and established normative range data can be useful in risk stratifying patients
  - To demonstrate more effective diuretic intervention and administration
  - To demonstrate a reduction in readmissions resulting from patients released with reduced fluid burden
- Gain FDA Clearance to remove implantable cardiac device contraindications
- Potential larger clinical study to establish home testing model predicated on significant reduction in 30-day readmission rates

RENAL FAILURE

Renal Failure

CE Mark obtained. US Regulatory strategy currently being formulated

- There are in excess of 450,000 US dialysis patients
- Centers for Medicaid and Medicare Services expects >44 million dialysis treatments in 2021
- More than 85% of these treatments will be performed in dialysis centres
- Those who live with End Stage Renal Disease are 1% of the Medicare population but account for 7% of the Medicare budget
- Unhealthy kidneys are no longer properly removing wastes and extra fluid from the body
- Most hemodialysis patients go to dialysis treatment three times a week for about four hours
- Protein calorie malnutrition or protein energy wasting, is common in patients with chronic kidney disease and is one of the strongest predictors of patient mortality
- SOZO technology adopted by AstraZeneca to measure fluid outcomes in heart failure patients with chronic kidney disease



$300+ Million

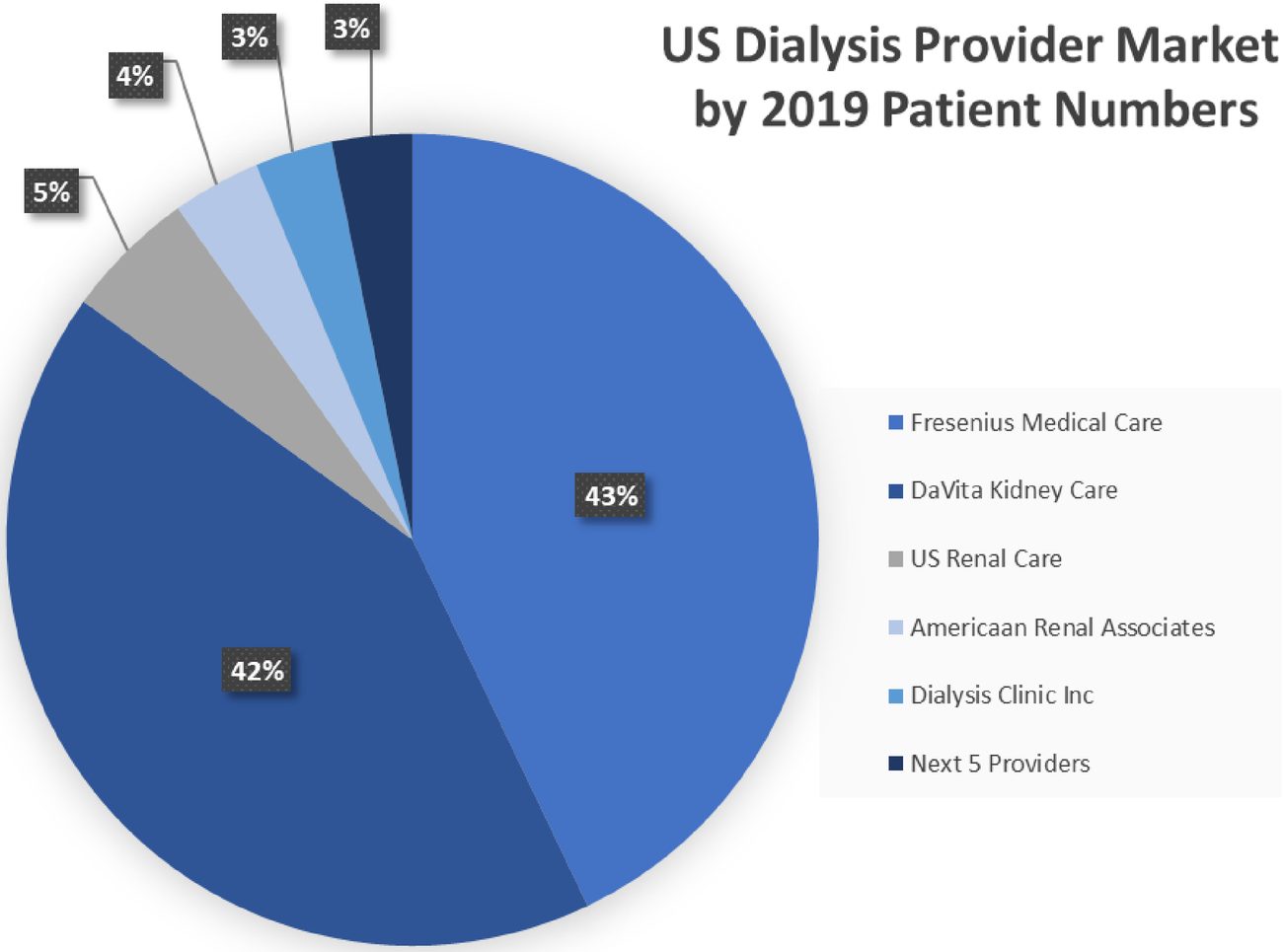
Annual Addressable Market[1]

1 ESRD and PCM testing at $2.50 per test

Renal Failure Market is Significantly Concentrated

The dialysis market is dominated by two companies: Fresenius and DaVita

- Concentrated market with Fresenius and DaVita caring for 85% of ESRD patients
- Fresenius and DaVita both operate more than 2,500 dialysis clinics each and together treated in excess of 400,000 ESRD patients
- Although a smaller market than Oncology or Heart Failure, the concentrated nature of the market makes it very attractive
- ImpediMed is currently in the process of formulating its clinical, regulatory and commercial strategies



SOZO and Dry Weight for Renal Failure

ImpediMed believes SOZO could provide a reliable scientific way of calculating dry weight

- Fluid is removed during dialysis to return the patient to his or her dry weight by the end of the treatment. Ideally, the goal is to target a weight where the patient will be normally hydrated (not feel thirsty) and feel comfortable.
- In most cases, dry weight is an estimate determined by your doctor, based on his or her experience and your input. Your doctor will prescribe your dry weight based on your weight when you have:
  - normal blood pressure
  - the absence of edema or swelling
  - neck veins that are not distended
  - the absence of lung sounds (rales and crackles) related to fluid overload
  - no shortness of breath or congestive heart failure
  - a normal size heart shadow on X-ray
- It is generally a clinical estimate since there are no reliable scientific ways of measuring dry weight.
- Dry weight should be assessed every three to six weeks and adjusted when a patient gains or loses actual weight.
- If you gained actual weight and your dry weight was not raised accordingly, too much fluid may be removed during dialysis. Tell your health care professionals if you believe your dry weight has changed.
- Not removing enough fluid; however, may leave the patient overloaded, put added strain on the heart and keep the blood pressure high. One of the most common reasons for a patient on hemodialysis to go to the hospital is for fluid overload.

- Kidney Care Website

Renal Failure - Key Takeaways and Next Steps

Key Takeaways

- There are in excess of 450,000 US dialysis patients
- Centers for Medicaid and Medicare Services expects >44 million dialysis treatments in 2021
- More than 85% of these treatments will be performed in dialysis centres
- Concentrated market with Fresenius and DaVita caring for 85% of ESRD patients
- Fresenius and DaVita both operate more than 2,500 dialysis clinics each and together treated in excess of 400,000 ESRD patients

SOZO has the potential to:

- Provide a reliable scientific way of guiding dialysis target fluid volume “dry weight”
- Reduce hospitalisations resulting from fluid overload

Next Steps

Announcements regarding:

- Clinical Strategy
- Regulatory Strategy
- Commercial Strategy

CORPORATE AND FINANCIAL OVERVIEW

Corporate Overview

ImpediMed is a medical software technology company that non-invasively measures, monitors and manages fluid status and tissue composition using bioimpedance spectroscopy (BIS)

ASX Listed
IPD.AX
October 2007

69 Total Staff
US (San Diego)
Australia (Brisbane)
Europe (Greece)

Share Register

Private:	63%
Institutional:	34%
Director & Management:	3%

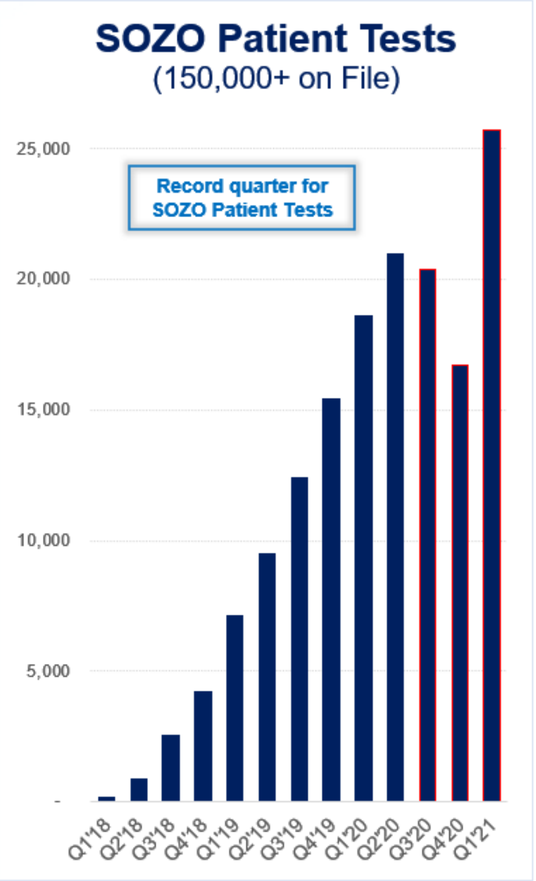
Market Cap: ~AU$89M
as at 26 October 2020
1.07bn shares on issue

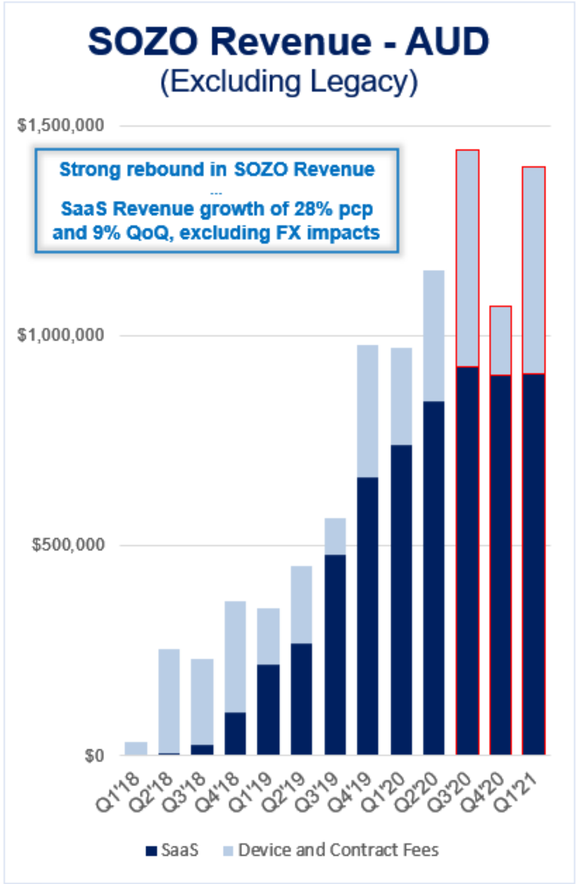
Cash on Hand: AU$15.4M
as at 30 September 2020
Additional AU$2.6M received from R&D Tax refund
Additional AU$15.7M from Options available

Debt: Nil
No borrowing from banks

Financial Overview – as at 30 September 2020

Revenues are predominantly for Lymphoedema only, prior to private pay reimbursement and Heart or Renal Failure revenues





COVID-19

- 150,000+ Patient Tests on file
- Churn Rate of just 1%
- 600+ Devices Sold to date
- 100% Renewal Rate

Key Takeaways

- Strong rebound across the entire business, despite COVID-19, driven principally by:
  - Adding new cancer centres
  - Expansion of key cancer centres (additional SOZO devices and indications)
  - Adoption of the Lymphoedema Prevention Program
  - Acceleration of patient testing

Resulting in:

- Record quarter for SOZO® Patient Tests, with over 25,000 recorded in Q1 FY'21, +42% from the previous corresponding period (pcp) and +54% quarter over quarter.
- SOZO Revenue for Q1 FY'21 of $1.4 million, +45% pcp and +29% quarter over quarter.
- Annual Recurring Revenue of $6.0 million, +54% pcp and +15% quarter over quarter.
- Contracted Revenue Pipeline of $13.1 million, +42% pcp and +20% quarter over quarter.
- AstraZeneca selected SOZO to be used in a Phase II trial to measure fluid volume in patients with heart failure and chronic kidney disease.
  - 175 SOZO devices will be leased across 20 countries over approximately 18 months, with the contract valued at over $2 million.
  - Recurring revenue to commence in late Q2 FY'21 and accelerate in Q3 FY'21.

Financial Summary

- Significantly strengthened balance sheet with closing cash balance at 30 September 2020 of $15.4 million.
- Received R&D Tax Incentive funds of $2.6 million in October 2020, resulting in a proforma cash balance of $18.0 million at 30 September 2020.
- Successful completion of a non-renounceable accelerated entitlement offer, raising $18.2 million before costs. As of 30 September 2020, the Company has received a further $2.5 million from the exercise of options issued to subscribers in the entitlement offer (with potential for up to a further $15.7 million to be raised by 31 March 2021, from remaining options issued in the offer).

Range of Selling Models

DIRECT CHANNEL

SOFTWARE-AS-A-SERVICE (US Market)

- No capital equipment fee, reducing sales process
- Up to U$1,500 per month for the first license
- Multi-year contract for license fees
- Ability to add licenses at any time during contract
- Other services during contract include training and warranty

HYBRID SaaS SALE (US Market)

- Capital equipment fee of up to U$5,000
- Up to U$1,500 per month for the first license
- Multi-year contract for license fees
- Ability to add licenses at any time during contract
- Other services during contract include training and warranty

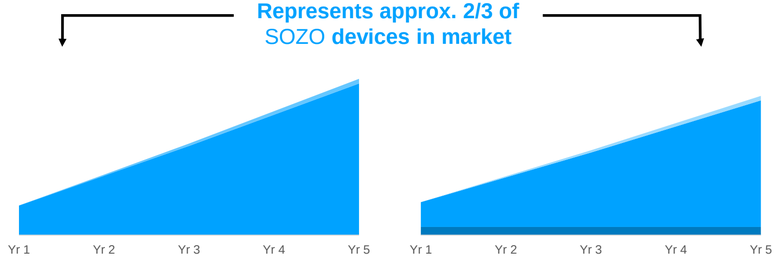
RENTAL (Global Clinical Trial Market)

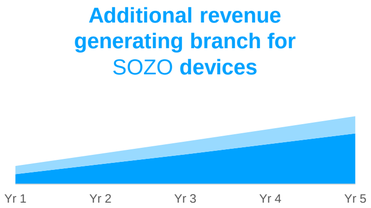
- Capital equipment fee built into rental fee
- Multi-year contract for rental/license fees
- Other services during contract include training and contract set-up fees

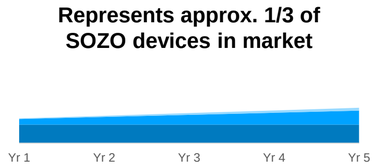
DISTRIBUTION CHANNEL

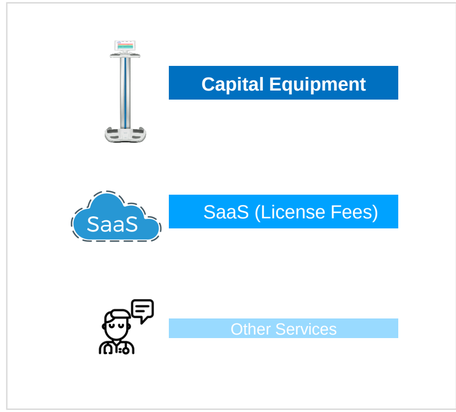
HYBRID SaaS SALE (Outside of US Market)

- Distributor purchases capital equipment
- Distributor sells capital equipment and license fees to end customer
- Distributor pays license fee to ImpediMed once sale to end user occurs
- Other services during contract include training, contract set-up fees and warranty
- License fees expected to increase with future applications









The information presented in these charts is for illustrative purposes only, in order to demonstrate the cumulative revenue associated with a single SOZO unit over five years under each selling model.

Expected Milestones and Upcoming News Flow

Oncology

- Continued strong growth in SOZO SaaS subscription-based business
- The Meta-Analysis has been accepted and is currently pending publication in the coming weeks
- Publication of an additional scientific paper assessing the risk of subclinical Lymphoedema by the extent of surgery and radiation
- Private payors begin coverage of L-Dex — catalyst for broad adoption in US
- PREVENT Trial 3-year data published
- NCCN Guidelines® — Applications for the addition of a formal testing protocol and inclusion of L-Dex

Heart Failure

- Commercialisation of SOZO in Heart Failure commences
- Heart Failure Paper published and presented
- Regulatory clearance for BIS in HF patients with implantable devices

Renal Failure

- Clinical, regulatory and commercial strategy announcements

APPENDIX

Management Team

Deep and Broad Commercialisation Experience

Richard Carreon
Managing Director and Chief Executive Officer

- Joined July 2012
- 30+ years experience
- Extensive experience in the medical device field and growth companies
- Previously Vice President at Medtronic (10 years)

Frank Vicini, MD
Chief Medical Officer

- Joined September 2014
- 25+ years as radiation oncologist
- Completed his fellowship at Harvard Medical School, has authored over 200 peer reviewed publications, and participated in 6 NIH clinical trials and the MammoSite Registry trial

Tim Cruickshank
Chief Financial Officer

- Joined January 2008
- 10+ years in financial management in the medical device / technology industry
- Experience in med-tech growth companies with a focus on SaaS modeling and strategy

Shashi Tripathi
Chief Technology Officer

- Joined July 2018
- 20+ years as a healthcare technology leader
- Previously SVP of Technology & Operations at New Century Health, where he oversaw all aspects of IT, project and product management, product development and operations

Catherine Kingsford
SVP Medical Affairs

- Joined January 2007
- 20+ years global clinical experience with medical devices
- Previously worked as a cardiac scientist at several world-class medical institutions including St. Andrew's War Memorial Hospital, The Prince Charles Hospital, and Royal Brompton Hospital

David Adams
SVP Operations and Strategic Planning

- On Board November 2013 to August 2016
- Joined August 2016
- Background as medical device investment & business development executive
- 25+ years experience in tax, financial planning, and business development
- Previously Vice President, Integrations and Divestitures at Medtronic

Dennis Schlaht
SVP R&D and Technology

- Joined October 2007
- 30+ years in engineering development and product marketing
- Previously Vice President of Marketing and Product Development at XiTRON's Test and Measurement Business

Nancy Deisinger
VP Human Resources

- Joined July 2016
- 20+ years in human resources, including 10+ years in medical device, working with start-ups to Fortune 500 companies
- Previously AVP Human Resources at 3E Company

Michael Bassett
SVP Corporate and Strategic Development

- Joined January 2020
- 25+ years experience in capital markets with senior roles at Australia's leading funds management and investment banking firms
- Previously MD Market Connect, a market consultancy business, Regal Funds Management, Credit Suisse, Deutsche Asset Management and Merrill Lynch

Board of Directors

Scott R. Ward
MS, BSc
Non-Executive Chairman

- Joined July 2013
- Appointed Chairman November 2017
- Venture capitalist with 35+ years experience in healthcare industry
- Currently Chairman, President and CEO of Cardiovascular Systems, Inc.
- Previously Senior Vice President and President of the Cardiovascular business of Medtronic

David Anderson
BSc
Non-Executive Director

- Joined May 2020
- 20+ years experience as executive in US healthcare industry
- Currently serves as President and CEO of HealthNow Systems Inc, operating as BlueCross BlueShield health plans in New York state
- Previously CEO of United Healthcare's Southern California Health Plan

Robert M. Graham
AO, FAA, FAHMS, MBBS, MD, FRACP, FACP, FAHA
Non-Executive Director

- Joined January 2018
- Received medical training at the University of South Wales where he is now the Des Renford Professor of Medicine
- Inaugural Executive Director, Victor Chang Cardiac Research Institute, Sydney Australia
- 17+ years experience in US healthcare and currently a consultant physician in cardiovascular diseases

Richard Carreon
Managing Director and Chief Executive Officer

- Joined July 2012
- 30+ years experience
- Extensive experience in the medical device field and growth companies
- Previously Vice President at Medtronic (10 years)

Judith Downes
BA(Hons), DipEd, GradDipBus(Acct), FAICD, FCPA, FCA
Non-Executive Director

- Joined April 2017
- 25+ years of accounting and senior management expertise with large ASX listed companies
- Previously a CFO at Alumina Limited and CFO/COO of Institutional Division, ANZ Banking Group Limited
- Currently Board Chairman of Bank Australia Limited, Honorary Fellow of the University of Melbourne's Faculty of Business and Economics, and Director, CleanTeQ Holdings Limited

Donald A. Williams
BAcy, CPA
Non-Executive Director

- Joined March 2017
- 35+ years in leadership roles serving the life science, biotech, and medical device industries
- Currently the Audit Committee Chair of Akari Therapeutics, Alphatec Holdings, Marina Biotech, and Proove Biosciences, and the Compensation Committee for Marina Biotech

Amit R. Patel
MBA, BME
Non-Executive Director

- Joined March 2017
- 8+ years in senior management positions across medical device, consumer software, and digital health organisations
- Currently Co-Founder and CEO of Murata Vios, Inc. (formerly Vios Medical, acquired by Murata Manufacturing)

Glossary

Glossary of Terms used by IPD	
Medical Revenue	The total revenue recognised during a given period related to the medical segment.
Annual Recurring Revenue (ARR) (i)	The amount of revenue reasonably expected to be booked for the next 12-month period based on existing contracts, and assuming installation upon sale.
Contracted Revenue Pipeline (CRP) (i)	The future period revenue amounts related to TCV that are yet to be reported as recognised revenue. Certain customer contracts that make up the Group's CRP contain cancelation clauses related to services yet to be performed. The Contracted Revenue Pipeline assumes no churn, highlighting the importance of customer experience and satisfaction.
Total Contract Value (TCV) (i)	The total value of customer contacts including one-time and recurring revenue.
Churn (i)	The total devices placed with end-user customer(s) who either (i) canceled while under their contracted period or (ii) elected not to renew their contract at the end of the contracted period.
Churn Rate (i)	[Churn] / [(Total device placements at beginning of period + Total device placements at end of period) / 2]
Renewal Rate (i)	[Total number of end-user customer contracts with expiration dates during the period that were retained] / [Total number of customer contracts with expiration dates during the period]

(i) ARR, CRP and TCV are unaudited, non-AASB financial metrics that do not represent revenue in accordance with Australian Accounting Standards.