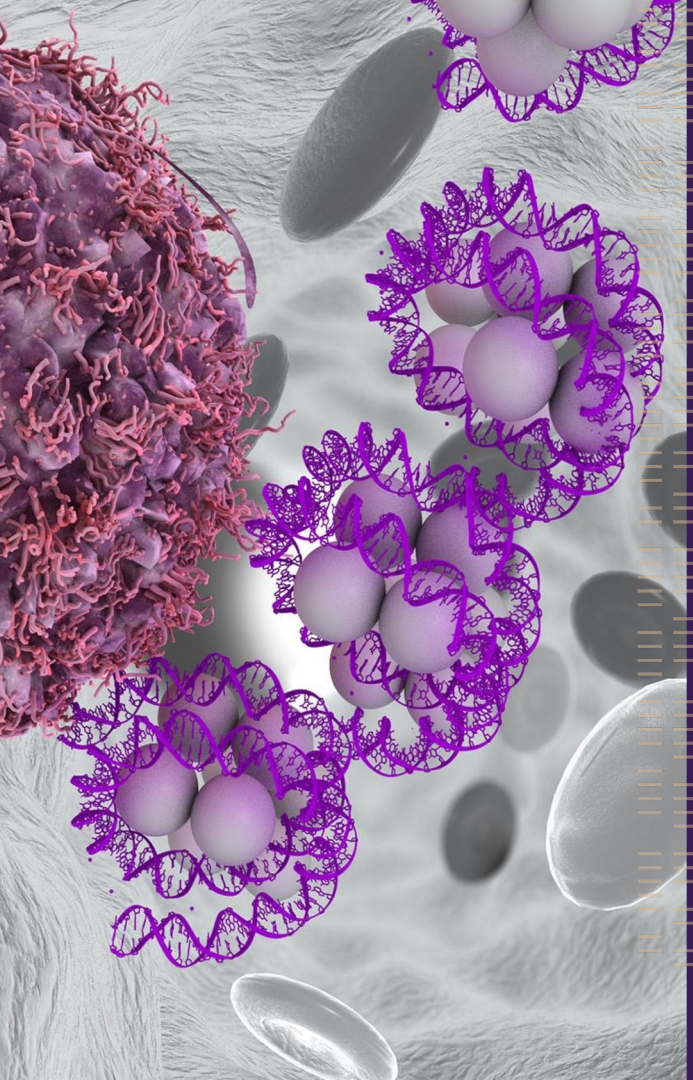

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GRAIL Analyst Call

American Society of Clinical Oncology

May 31, 2026

Legal Disclosures

This presentation contains forward-looking statements. In some cases, you can identify these statements by forward-looking words such as “aim,” “anticipate,” “believe,” “continue,” “could,” “estimate,” “expect,” “intend,” “may,” “might,” “plan,” “potential,” “predict,” “should,” “would,” or “will,” the negative of these terms, and other comparable terminology.

These forward-looking statements, which are subject to risks, uncertainties, and assumptions about us, may include expectations of our clinical studies, future tests or products, technology, regulatory compliance, potential market opportunity, anticipated growth strategies, applicability of results to a broad population, and interpretations of these results by regulators or payers, among others. These statements are only predictions based on our current expectations and projections about future events and trends. There are important factors that could cause our actual results, level of activity, performance, or achievements to differ materially and adversely from those expressed or implied by the forward-looking statements, including those factors and numerous associated risks discussed under the section entitled “Risk Factors” in our Quarterly Report on Form 10-Q for the periods ended March 31, 2026 (the “Form 10-Q”). Moreover, we operate in a dynamic and rapidly changing environment. New risks emerge from time to time. It is not possible for our management to predict all risks, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results, level of activity, performance, or achievements to differ materially and adversely from those contained in any forward-looking statements we may make.

Forward-looking statements relate to the future and, accordingly, are subject to inherent uncertainties, risks, and changes in circumstances that are difficult to predict and many of which are outside of our control. Although we believe the expectations and projections expressed or implied by the forward-looking statements are reasonable, we cannot guarantee future results, level of activity, performance, or achievements. Our actual results and financial condition may differ materially from those indicated in the forward-looking statements.

Except to the extent required by law, we undertake no obligation to update any of these forward-looking statements after the date of this presentation to conform our prior statements to actual results or revised expectations or to reflect new information or the occurrence of unanticipated events.

GRAIL at ASCO 2026

NHS-Galleri Trial

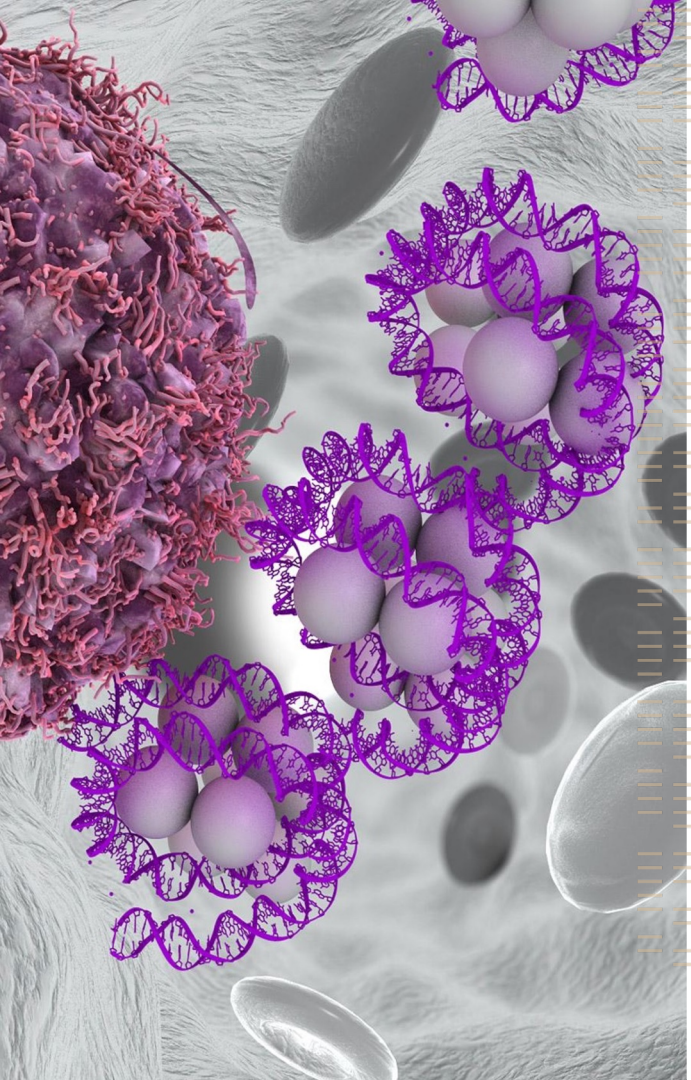
First randomized controlled study of an MCED test

Evaluated annual screening with the Galleri test in addition to standard of care screening over three years in more than 142,000 participants

PATHFINDER 2

Largest interventional MCED study in North America

Evaluated performance of a single MCED test in an asymptomatic population of ~35,000 individuals aged 50+



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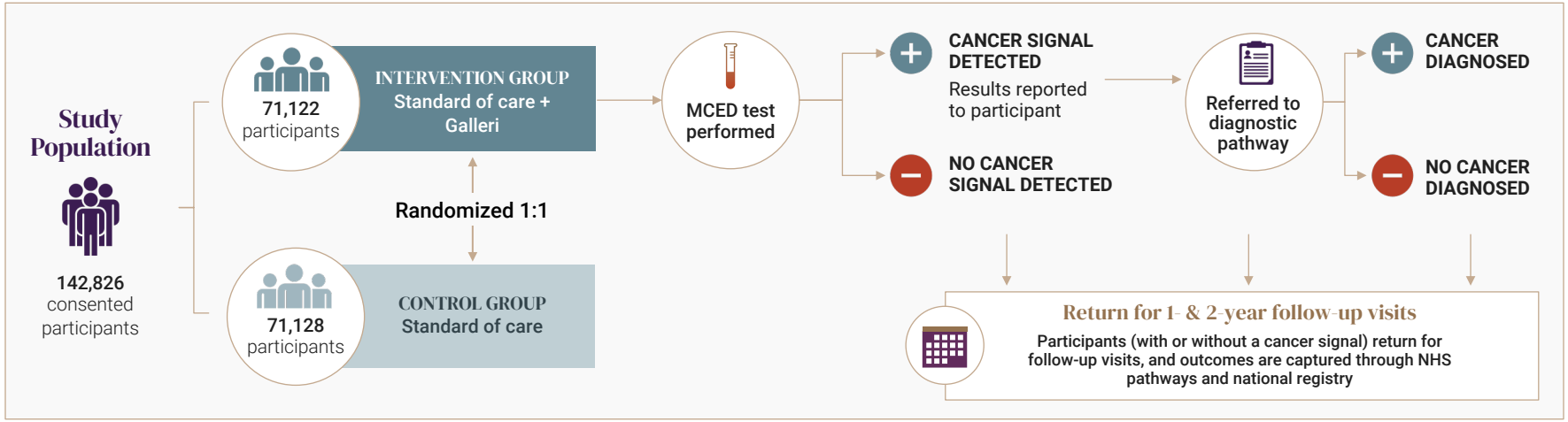
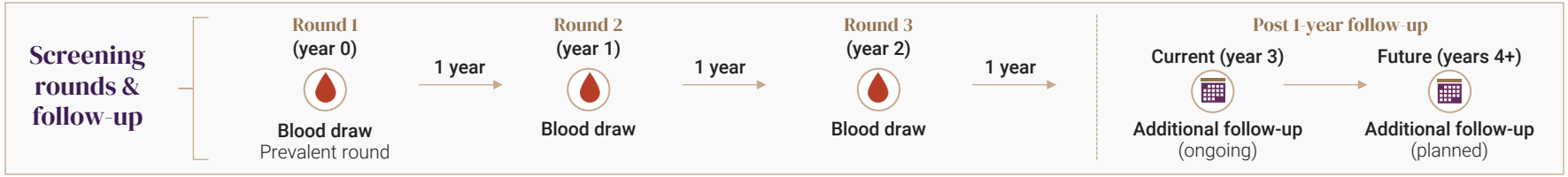
NHS-Galleri

NHS-Galleri: The First and Only Randomised Controlled Clinical Utility Trial of an MCED Test





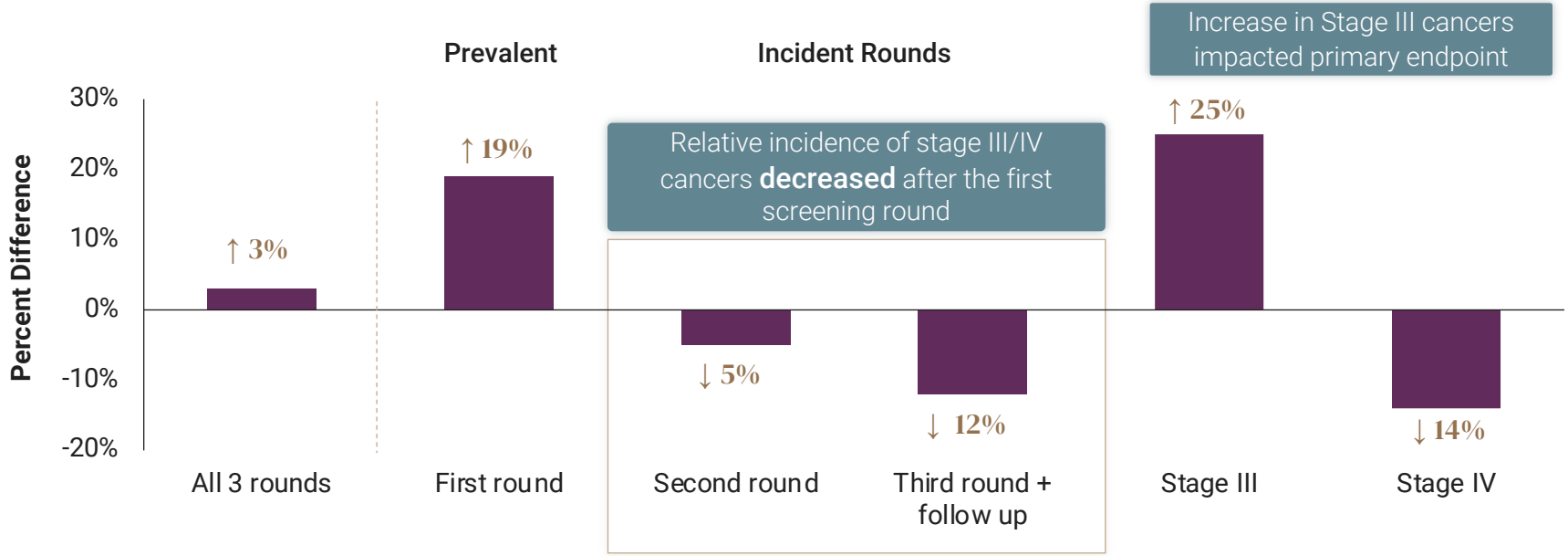
Three annual screening rounds with additional follow-up to assess long-term impact on cancer outcomes

The NHS-Galleri Trial Assessed Multiple Endpoints

Endpoint	Finding
Primary | Reduction in combined Stage III and Stage IV cancers 12 deadly cancers	Combined reduction not significant
Secondary | Reduction in Stage IV cancers 12 deadly cancers	>20% reduction in incident rounds
Secondary | Increase in Stage I and Stage II cancers 12 deadly cancers	~16% more Stage I/II cancers detected
Secondary | MCED Test Performance & Safety All intervention arm participants	52% PPV | 0.45% False Positive Rate Episode sensitivity 31% All; 55% 12D CSO Accuracy 92.5% No Serious Related Adverse Events
Exploratory | Increase in total cancers detected vs. SOC All detected cancers	4x as many cancers detected when added to SOC vs. SOC alone
Exploratory | Reduction in Clinical & Emergency Presentation All detected cancers	21% reduction in clinical presentation 25% reduction in emergency presentation

Primary Endpoint: Here is What We Observed

Change in stage III/IV cancers diagnosed (intervention v control)—12 pre-specified cancers

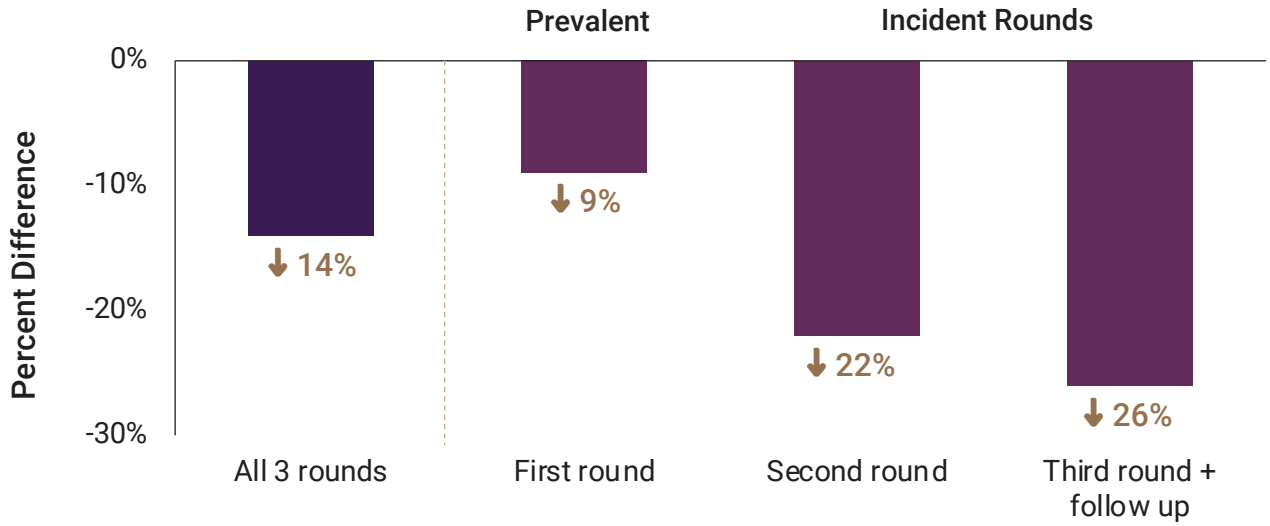


	All 3 rounds	First round	Second round	Third round + follow up
Incidence Rate Ratio (Intervention/Control)	1.03 (0.92, 1.14) p=0.6234	1.19 (0.98, 1.43)	0.95 (0.77, 1.17)	0.88 (0.73, 1.07)

Denominator is control arm; measured on the 12 pre-specified types were lung, head & neck, colorectal, pancreas, myeloma/plasma cell neoplasm, liver/bile duct, stomach, esophagus, anus, lymphoma, ovary, and bladder.

The Intervention Arm Showed A Clinically Meaningful Stage IV Reduction: ≥22.0% Reduction in Incident Rounds

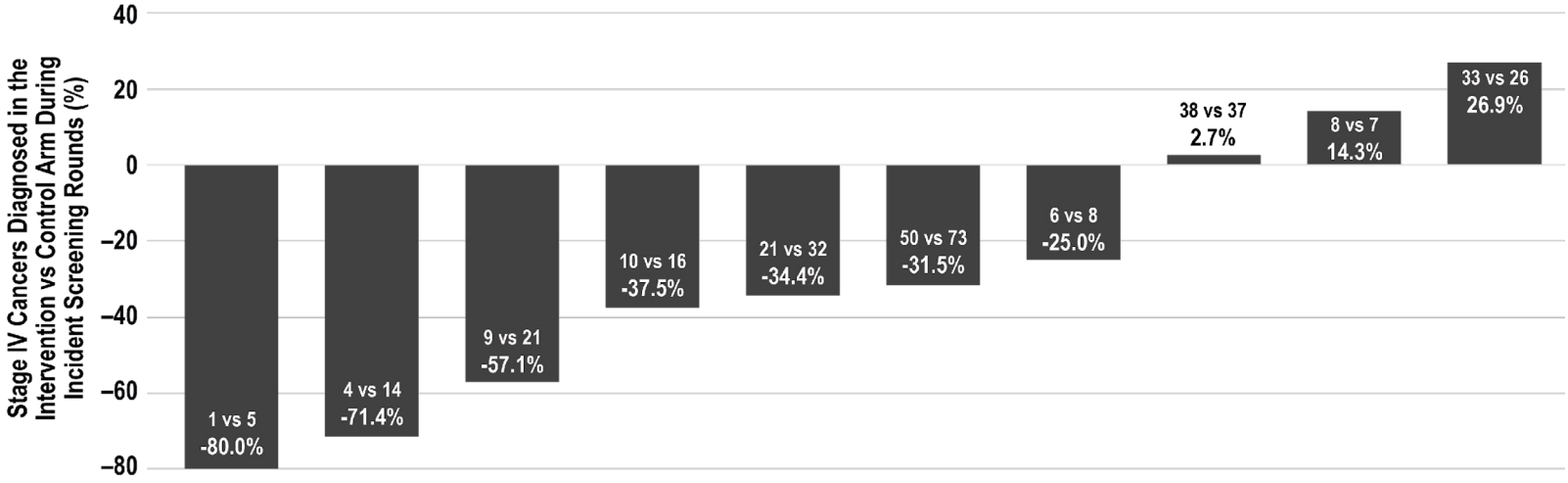
Change in Stage IV Cancers Diagnosed (Intervention v. Control) - 12 Pre-Specified Cancers



Incidence Rate Ratio (Intervention/Control)	0.86 (0.744, 0.998)	0.91 (0.71, 1.18)	0.78 (0.57, 1.06)	0.74 (0.57, 0.95)

Denominator is control arm; measured on the 12 pre-specified types were lung, head & neck, colorectal, pancreas, myeloma/plasma cell neoplasm, liver/bile duct, stomach, esophagus, anus, lymphoma, ovary, and bladder.

Detecting Cancers Prior to Stage IV Has Real Benefits For Many Cancers



		Bladder	Liver/bile duct	Oesophagus	Head & neck	Colorectum	Lung	Stomach	Lymphoma	Ovary	Pancreas
England 5-year net survival estimates[a,1]	Stage IV	5.8%	2.6%	6.2%	38.4%	11.0%	4.5%	4.5%	65.7%	16.2%	2.1%
	Stage III	31.8%	13.5%	24.7%	54.5%	64.2%	16.7%	24.6%	72.6%	32.4%	8.7%
	Difference	+26.0%	+10.9%	+18.5%	+16.1%	+53.2%	+12.2%	+20.1%	+6.9%	+16.2%	+6.6%

12 prespecified cancer types were lung, head & neck, colorectal, pancreas, myeloma/plasma cell neoplasm, liver/bile duct, stomach, esophagus, anus, lymphoma, ovary, and bladder. Anus and myeloma/plasma cell neoplasms were excluded from the graph due to having only 0 to 1 stage IV cancers in each arm. [a]For patients diagnosed in England 2016-2020 (all ages) by stage at diagnosis. [1]Cancer Survival in England, cancers diagnosed 2018 to 2022, followed up to 2023. 2026. Accessed May 19, 2026. https://digital.nhs.uk/data-and-information/publications/statistical/cancer-survival-in-england/.

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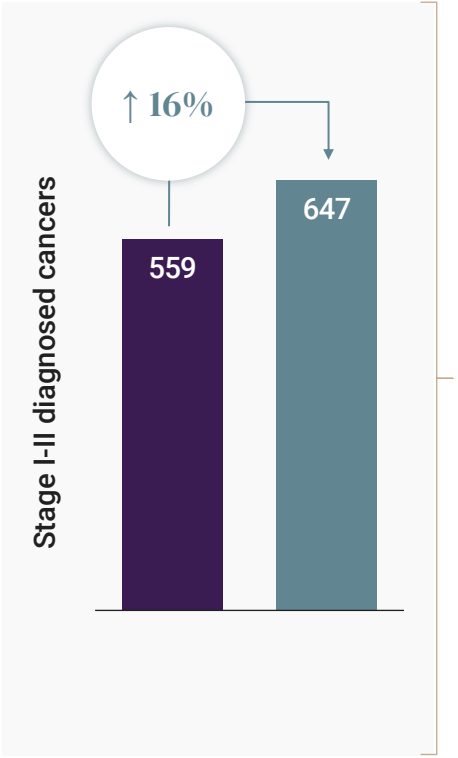
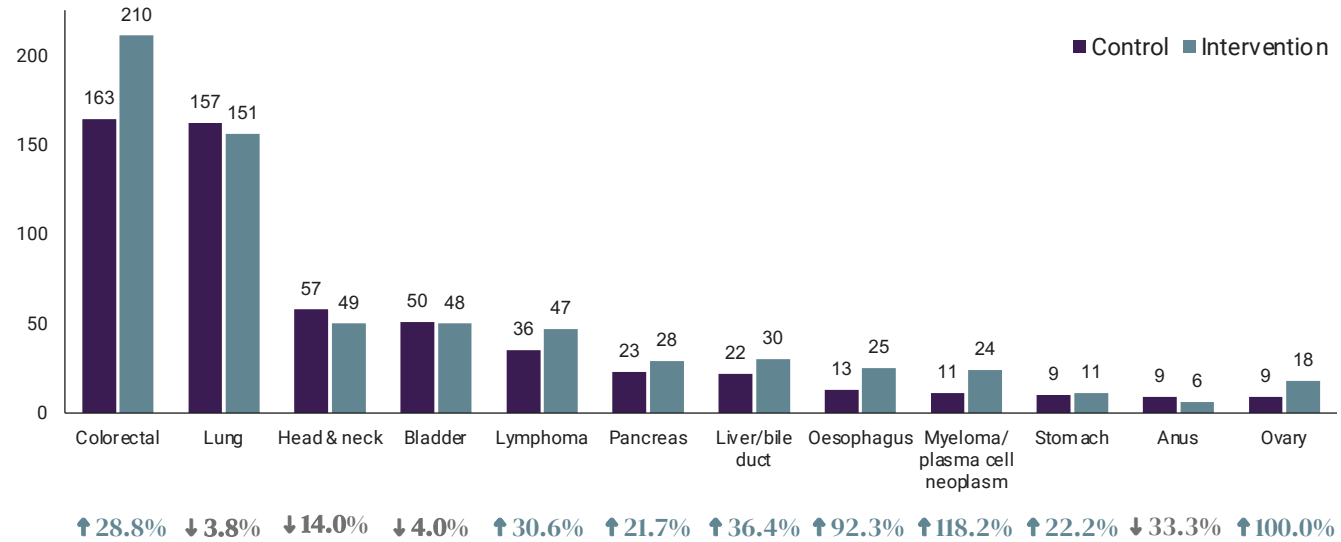
16% More Stage I-II Cancers Were Identified in the Intervention Arm





MCED, multi-cancer early detection; SOC, standard-of-care
[a]12 Prespecified Cancer types were lung, head & neck, colorectal, pancreas, myeloma/plasma cell neoplasm, liver/bile duct, stomach, esophagus, anus, lymphoma, ovary, and bladder. [b]Per highest stage.
Charles Swanton, MD, PhD

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Robust MCED Test Performance in UK Population

Aggregate MCED Test Performance Over 3 Screening Rounds[a]

		Cancer Status: Cancer diagnosis (n=3,051)	No cancer diagnosis (n=194,095)	Total (N=197,146)	Performance metric (95% CI)
MCED Test Result	Positive	937	864	1,801	**PPV[b] 52.0%** (49.7-54.3%)
	Negative	2,114	193,231	195,345	**NPV 98.92%** (98.87-98.96%)
Performance metric (95% CI)		**Episode sensitivity[c] 30.7%** (29.1-32.4%)	**Specificity 99.55%** (99.52-99.58%)		

CSO Accuracy
92.5%
(90.7-94.0%)

PPV
First screening round
58.0%
(54.4-61.6%)

12 Prespecified cancer types

Episode sensitivity[c] aggregated across rounds
54.7%
(51.8-57.5%)

First screening round
63.4%
(58.9-67.7%)

Episode sensitivity[a]
First screening round
37.2%
(34.4-40.0%)

MCED, multi-cancer early detection; NPV, negative predictive value; PPV, positive predictive value.
Intervention-arm test performance analysable set. a Calculated using all participants within the performance analyzable set, defined as participants who were clinically eligible and evaluable and had evaluable MCED test results; third round follow-up time was 12 months. b PPV for the first (prevalent) screening round only was 58.0% (54.4-61.6%). c12-month episode sensitivity was calculated as the number of participants with a positive MCED test result and a cancer diagnosis within the follow-up period for that round out of all participants with a cancer diagnosed in that round.

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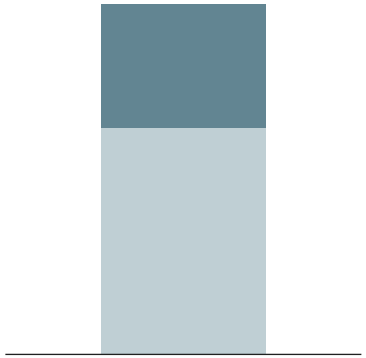
Trial Demonstrated Low False Positive Rate & No Related Serious Adverse Events

864 false positives
(303 in first screening round)

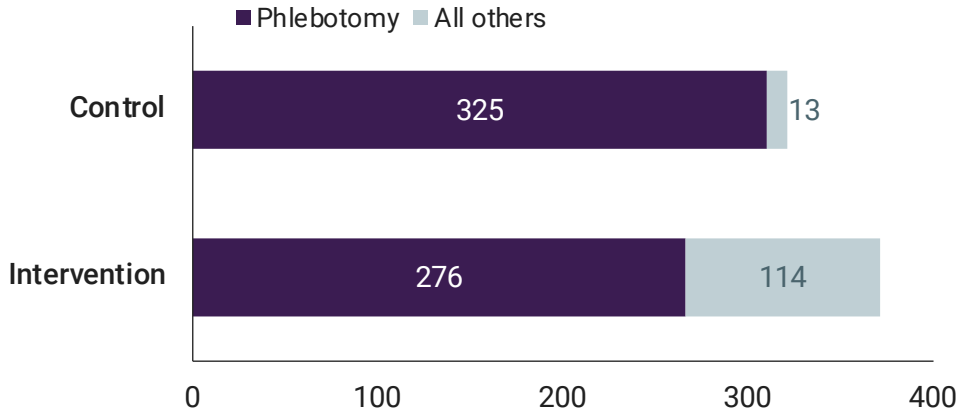


54/303 (17.8%) were subsequently diagnosed with cancer in the second or third screening round

Of these, 44/54 (81%) had a correct CSO prediction in the first screening round

Number of adverse events

0.45% *(321/71,128) and* ***0.52%*** *(371/71,122) participants in the control and intervention arms, respectively, experienced a study-related AE collected from blood sample collection up to referral into NHS*



No serious study-related AEs occurred from blood sample collection or return-of-test results

CSO, cancer signal origin; MCED, multi-cancer early detection.
AE, adverse event; MCED, multi-cancer early detection; SOC, standard-of-care.
All other adverse events includes participants with AEs other than phlebotomy, such as anxiety, emotional distress, dizziness. Note: a participant may have had more than one adverse event.

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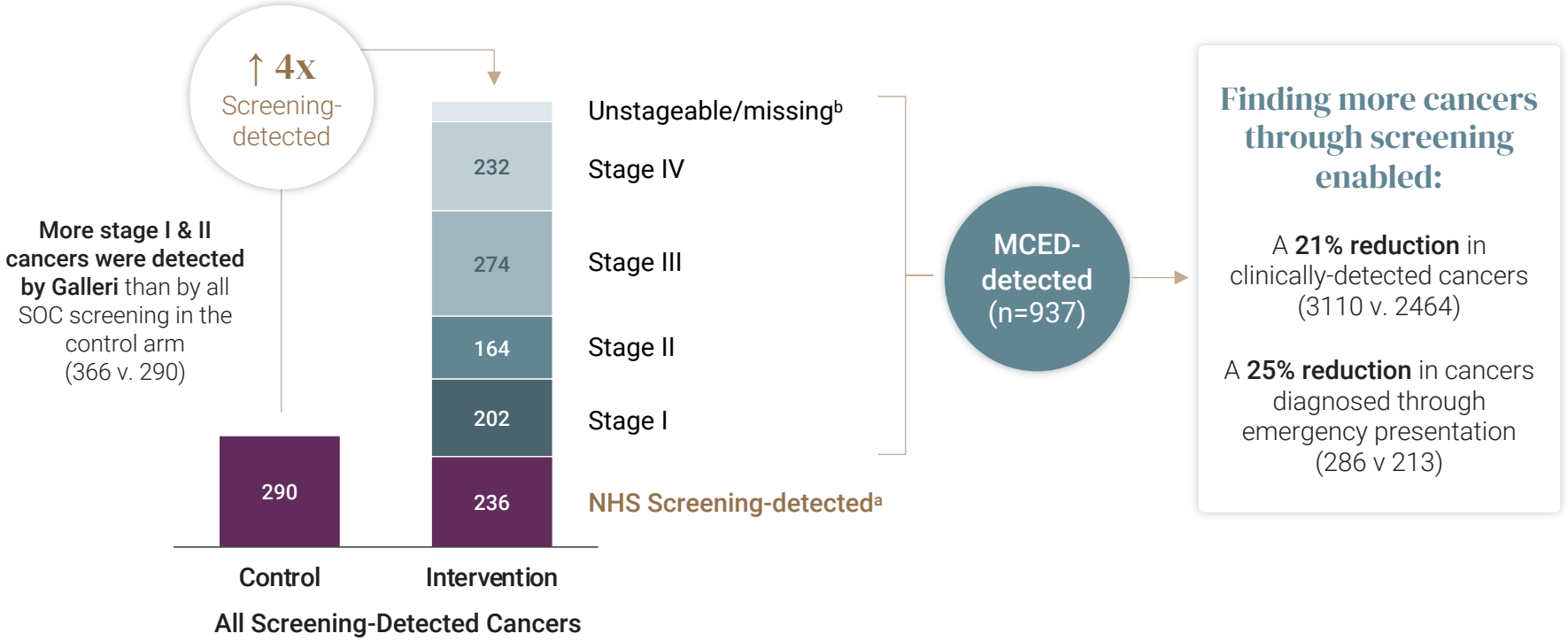
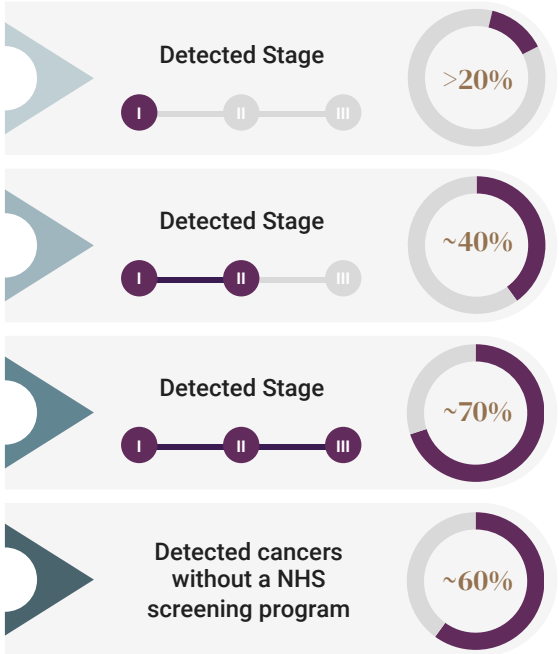
Adding Galleri to Standard of Care Quadrupled the Number of Screening-Detected Cancers



MCED, multi-cancer early detection.
[a]Breast, colorectal, cervical, and lung (for high-risk individuals) cancer. [b]Includes 10 unstageable cancers (no staging system exists) and 55 cancers with missing stage information.

Galleri Detected Many Deadly Cancers at Early Stages

Cancer Type	I	II	III	IV	NA	Total
Colon/Rectum	56	45	63	27	2	**193**
Lung	13	14	60	44	1	**132**
Prostate	16	8	37	42	2	**105**
Lymphoma	11	10	20	30	1	**72**
Breast	10	29	11	9	1	**60**
Plasma Cell Neoplasm	4	4	0	0	36	**44**
Esophagus	4	9	17	10	3	**43**
Pancreas	2	4	6	23	1	**36**
Head & Neck	22	3	7	3	0	**35**
Ovary	6	3	17	9	0	**35**
Liver/Bile Duct	11	12	6	4	1	**34**
Lymphoid Leukemia	19	3	0	0	4	**26**
Stomach	1	5	7	6	0	**19**
Uterus	8	3	3	4	0	**18**
Gallbladder	0	4	4	7	0	**15**
Kidney	1	3	5	3	2	**14**



MCED, multi-cancer early detection.
Total Galleri cancers detected are 937; table excludes cancer types with 10 or fewer detected cancers: Bladder, Anus, Melanoma, CUP, Mesothelioma, Small Intestine, Germ Cell, Vulva, Brain, Penis, Vagina, Multiple Cancers, Sarcoma, Urothelial Tract, Cervix, Thyroid
NA indicates missing or unstageable cancers

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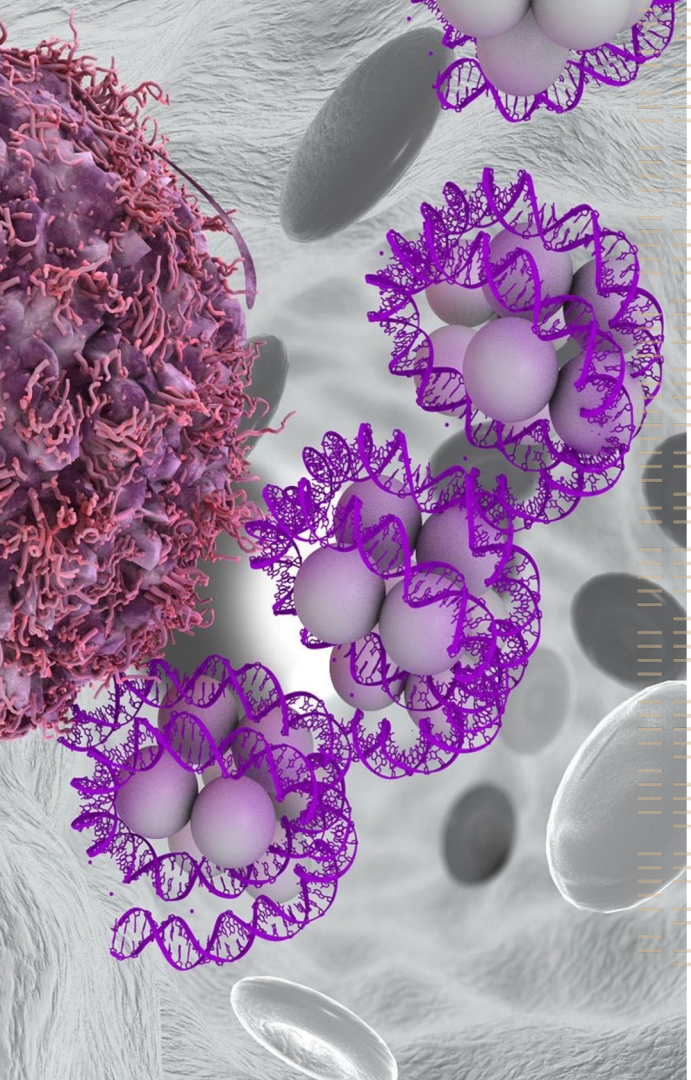

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PATHFINDER-2

PATHFINDER 2: The Largest Interventional MCED study In North America

35,878 Participants Age ≥50 Years

from 32 North American healthcare systems with 3 years of follow-up

CANCER SIGNAL DETECTED

Test result communicated

Diagnostic follow-up procedures[b] (recommend in protocol based on CSO)

NO CANCER SIGNAL DETECTED

Test result communicated

Diagnostic resolution

CANCER IDENTIFIED

NO CANCER IDENTIFIED

Protocol-specified diagnostic PET-CT
Research blood draw

Follow-up and planned analyses

Blood draw

12 months (current data)

Current results reflect ~12 months of follow-up

24 months (year 2)

Planned interim analysis

36 months (year 3)

Planned final analysis

Up to 3 years of follow-up

Primary Objective: Evaluate safety and performance of the MCED test in a large, diverse intended use population

Full PATHFINDER-2 Results Were Strong & Consistent With the First 25k

Performance metrics

~60% PPV

~0.4% False Positive Rate

>90% CSO accuracy

>70% Episode sensitivity for 12 deadly cancers

>70% Galleri detected cancers were Stage I-III and **~50%** were Stage I-II

Cancer detection rate

6.5x cancers detected

When added to USPSTF A/B screenings(1)

3x cancers detected

When added to all SOC screenings(1)

Safety

No serious study-related adverse events

85%

diagnostic evaluations were non-invasive

<1% participants had an invasive procedure

Invasive procedures were more common in cancer vs. no cancer (91% vs. 50%)

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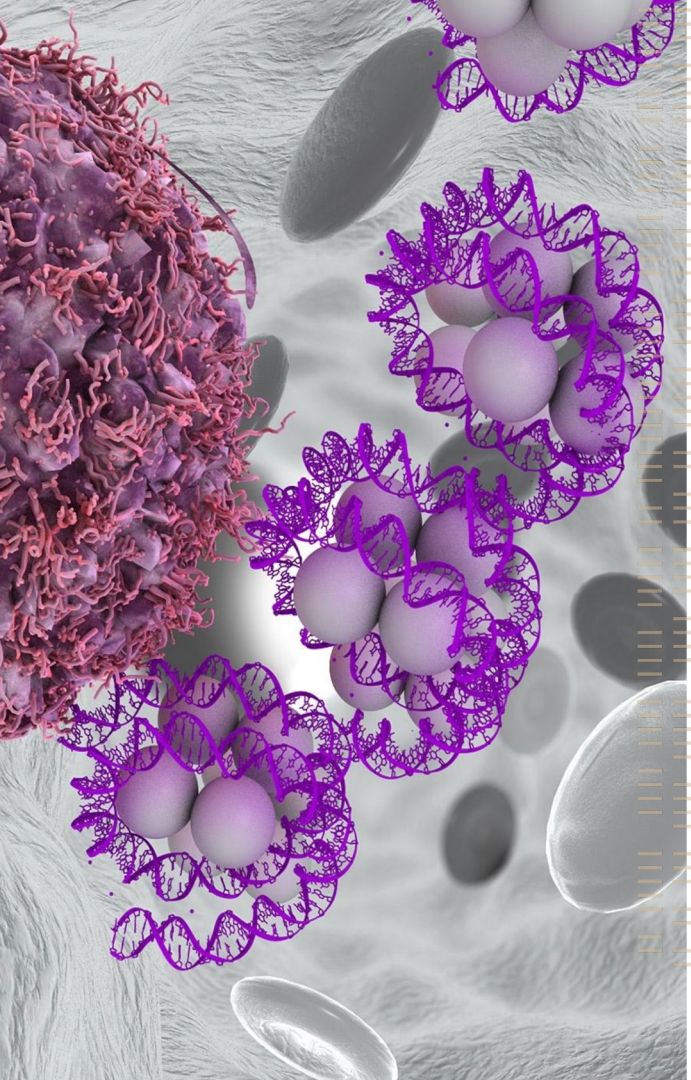
(1) SOC screening includes Breast, Lung, Colon, Cervix, and Prostate; USPSTF A/B Screenings are: Breast, Lung, Colon and Cervix. Prostate cancer has a USPSTF C rating.



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Summary

Strong and Consistent Performance Across ~180,000 Participants in NHS-Galleri & PATHFINDER 2

First demonstration of stage shift after 3 years of MCED screening

- >20% reduction in stage IV cancers after the first screening year
- Increase in stages I and II cancers
- 25% fewer cancers were diagnosed after an emergency presentation

Adding Galleri to SOC enables detection of substantially more cancers

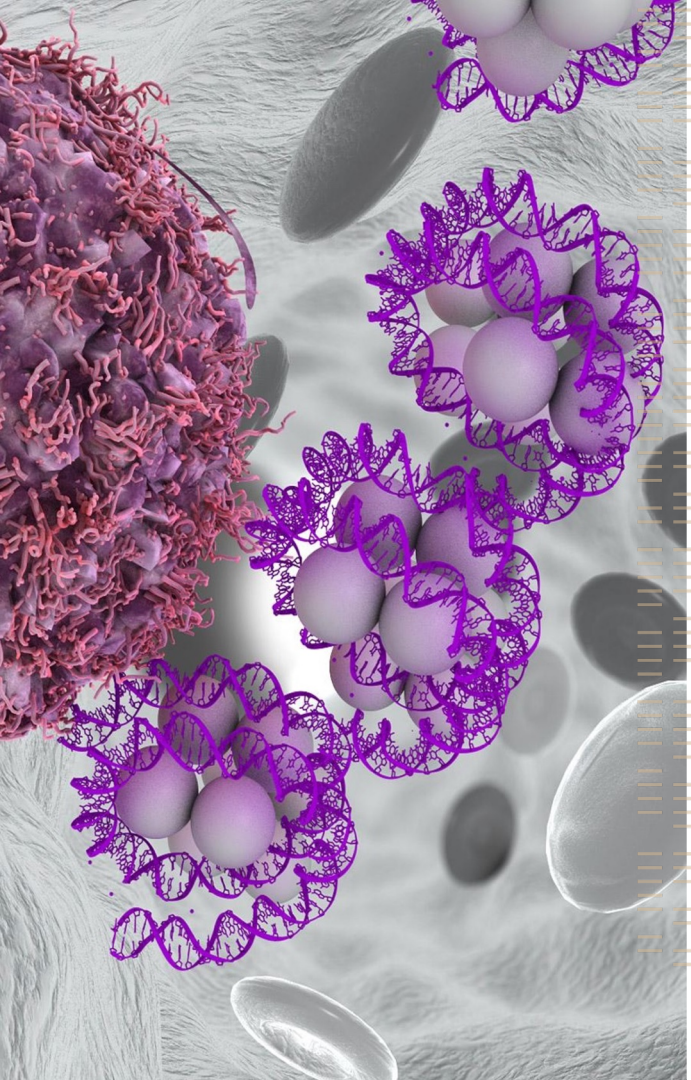
- Between 4x and 6.5x the number of cancers detected when added to standard-of-care screening
- Enables detection of deadly cancers without existing screening options

Consistently high performance that enables confident, real-world use

- Consistent results across studies
- ~60% PPV for PATHFINDER 2 and >50% PPV in the first screening year for NHS-Galleri
- Less than 0.5% False Positive Rate

Actionable results that drive efficient, patient-centered care

- Consistently accurate (~90% or higher) cancer signal origin prediction enables rapid, directed diagnostic resolution



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Q&A