Diasorin S.p.A.

"2026 Investor Day"

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MODERATORS: MICHELE DENEGRI, CHAIRMAN

CARLO ROSA, CHIEF EXECUTIVE OFFICER

ALBERTO DONATI, CHIEF FINANCIAL OFFICER

CHEN EVEN, CHIEF COMMERCIAL OFFICER

ANGELO RAGO, PRESIDENT LUMINEX CORPORATION

GIULIA AMICARELLI, VICE PRESIDENT, GLOBAL MOLECULAR MARKETING & MARKETING SERVICES

CARLO ROSA: So let's start. Good morning to everybody. Welcome to this very important day for this company. It's a 5-year plan, and we will try in a couple of hours to tell you where the company is going to go, which is very exciting in the next 5 years. Mr. Denegri, our Chairman, will give a welcome speech, and then I will follow-up with an introduction. Michele, please go ahead. Gracias.

MICHELE DENEGRI: Can you hear me? [Foreign Language]. And for the benefit of who is connected overseas or who doesn't speak Italian, it makes my life more complicated, so I will be in English. Welcome. I have some notes because I have a few messages, but very important, and I have to have the right words.

It's a very important day for us today, and I think it's going to be also an enjoyable day. I do believe we will enjoy what we will present, that is a plan, a mid-term plan of Diasorin, but it makes sense of the future of Diasorin. What I'm trying to do is to be very quick, because I know you're impatient to go to facts, but if I can make a value today, it is in a way to express and deliver messages about what is behind numbers and facts.

The first message for me, very important to give to you today, is my real confidence in the plan. I've been participating somehow on building the plan, assisting Carlo, and the first amazing experience I had is how the plan has been made and built from the bottom of the company, having a large, strong commitment by the team…by the management team, by the team of people. And I have to tell you that I felt the enthusiasm on doing it, on believing in it. That was contagious.

It is a moment in which the world represents a very complex way of being understood. It's uncertain, but I'm sure that you agree that diagnostics, In Vitro Diagnostic, and diagnostics in general, still

remain a solid and important and essential role in the acquired system that is moving, that is evolving.

Our future in this very dynamic world is very promising, by the fact that we have a real strong offer in terms of platform and products. And you will see in detail in the plan presentation how it's obvious, it's credible. It's time to execute. It gives me the confidence that the plan is compelling and can be successfully executed. I don't have no doubt that Diasorin has always been, and I'm 25 years involved in Diasorin, when it's time to execution, it's really like performing excellently.

I don't want to get long in terms of confirming the fact that Diasorin has a clear identity. I think, it's obviously understood by you that know the company, how much we're being understood in the world as a specialty company. And somehow this way of being, in the future, for how the healthcare system in the diagnostic field is evolving, I think will be even more privileging, the fact of being a specialty company.

The healthcare system is under pressure, it's clear as well. Population is aging, chronic diseases are increasing, medicine is becoming more precise, more personalized, and more connected. Testing is moving closer to patients in some areas, while laboratories are asking for more automation, more efficiency, and better integration in others.

And this is why I'm saying that Diasorin is facing this kind of polarization, made by the fact that point-of-care is becoming the future, and because laboratories and hospitals are asking for growing, in terms of efficiency and always better solution. And we are ready to present ourselves to solutions in both situations.

In particular, in immunodiagnostics, that is our DNA, what Diasorin became since Carlo, in 2000, decided to launch a management buyout. It's clearly strong because there's a broad, enormous range of products,

and different platforms, that can really match the need of hospitals and clinical labs.

In molecular diagnostics, with the multiplexing platform, the new NES you saw in the entrance, it's finally matching, and it's starting now to be distributed with enthusiasm. Life science technology is something that was not in our life science technology and general science. Life science has always been Diasorin until Luminex took us there.

And we see the strategical potential it has for Diasorin. It helps us to get closer to the more advanced players in the world, being connecting, sharing R&D, and it's allowing us to build our future through strategic alliance. We're leading international play, even if we're not in the same field we are with our IVD.

Today, the management team will cover all the essential aspects. Carlo will start us first, presenting the strategic overview, and positioning Diasorin in the global diagnostic market. Then, we will go through the different divisions of immunodiagnostics, molecular license. Giulia, Chen, and Angelo will take you, explaining in details about platform products, commercial opportunities, and strategic programs.

And finally, where is Alberto? Mr. Alberto Donati, the new CFO of the company, congratulations for your…good luck for your first Capital Market. We'll drive you to the most juicy part, that is, presenting financial frameworks, and including the objective and discipline that we get Diasorin over the coming years.

We will also, thanks to Alberto, explore about ESG priorities. I'm personally very proud about Diasorin Foundation and what we do. And I also believe that it's clear to all our employees, management team, people that work for Diasorin, as they called us, that for Diasorin, sustainability is not separate from our business, it's really a

way of being. It's part of our responsibility to our people, to our communities, and to the world in which we operate.

I think in conclusion today, you will see that we have an exciting future ahead, and a compelling strategy to achieve it, which is rooted in the differentiation of technology and the capability of Diasorin in our people, in our culture, and consistent execution.

The last message that is due to me is about the capital allocation. You will see that the plan, 2026-2030, will show a strong generation of cash, and it's clear that we have 3 priorities in order how to use the cash, and first of all will be to support the company, to reinvest in it, and continue to support our growth, R&D, people, and of course in innovation and capabilities.

In addition, we will keep on a consistent policy in dividends, as in the past. And for last, but seriously thinking about being ready if opportunistic bolt-on acquisition can come to our future, as in the past, not growing just for growing, but once we see that something can be strategically and operative synergy, we will not waste time and go. And eventually, opportunistic buyback like we've done recently.

Besides what I said, believe me when I say that I'm proud of Diasorin. It's 25 years I'm involved in the company. I feel it fresh, contemporary, with an avant-garde way of thinking. I feel totally committed to the board, to Carlo, and to the team and to the employees of Diasorin Org. Thank you so much for coming to the meeting.

CARLO ROSA: Okay. So good morning. I'm going to spend 15 minutes to give a strategic overview, and then I really would like to leave the podium to the management team, to the people that are actually driving the businesses and have the responsibility to deliver this plan.

It's a very interesting time. As you all know, the context is unique. The world that we're living today is unique. The fact that China, that all of a sudden was a hope for everybody, now is not there any longer, at least in our sector. The fact that the supply chain is strained, and the fact that there are tariffs, and therefore there is value in localization. Until yesterday, there was value in globalization. So certainly, this plan is very well thought in the context where we live and we sit today.

Now, let's go back one second, and let's talk about where are we today versus the last Investor Day. And the last Investor Day was in 2023. It seems ages ago. And what did we do back then? The big thing was Luminex acquisition, right? Which was disputed, discussed, explained. And what gave us that acquisition? It gave us a couple of very relevant things. It made us a US company, and that was the strategic intent. US today represents 50% of the revenues, 60% of the Diasorin employees are in the US. And fundamentally, it gave us structure, organization, critical mass to access the #1 IVD market in the world. It represents 40% of the worldwide market.

It gave us access to 900 hospitals in the US, which as you know if you follow the company, gave us the opportunity to grow significantly in the last 3 years. It gave us the opportunity to do business development with the Huizhou in life science and biotechnology. Thermo Fisher, Biotechnique, Bio-Rad, they're all Diasorin partners and customers with the LTG technology.

So if we are here today to say that we can live without China, right? It's because in 2021, we decided to be…embed a lot in the US, okay? And it's funny, sometimes I'm still challenged, why did you buy Luminex? Right, I think we should be I think it should be very clear why we decided to buy Luminex.

Now, let's go back one sec to the market we played in. It used to be €70 billion, €80 billion, the glory days of COVID. COVID is gone,

right? So we go back where we started in 2019. Dynamics are very similar. It's a $60 billon market. It seems big, but compared to pharmaceutical, it's nothing. Pharmaceutical is 1.5 trillion, right? So it's a small market. It's a market today that is fragmented. There are 4, 5 players they control 65% of this market, Roche being the #1, and a very reputable company. It's growing, yes. It's growing 3%, but it's not growing enough to guarantee high-single-digit growth. So in this situation, if you want to deliver 6%, 7%, 8% growth, you need to go out and gain market share from competitors.

So the leitmotif that you're going to hear today is that we will grow because we become more leaders in certain segments of the market where we believe we are better than competitors. But there are trends in healthcare which is known to all of you, that I think make the decision complicated for management, right? You need to take…you need to consider the demographic shift, so aging population. We will see what it means. You need to realize that when it comes to Europe and the US, there is consolidation in core labs because hospitals need to become more efficient, and the only way they have to do it is to close small labs and open big labs.

By the same token, in the rich markets, especially in the US, there is decentralization, because it makes ton of sense to decentralize. But at the same token, there is no money. There is no money…there is no more money for healthcare. This is the truth of the matter. In Europe, we know it very well. We've been asked to spend more money in defense. That means that there is going to be less money for healthcare, right, because typically pensions are not touched. And that means that if you really play into this sector, you need to create products that also bring value and savings to the hospitals.

Last but not least, there is a tremendous opportunity which is driven by the pharmaceutical companies and the switch from the traditional

drugs into this new generation of drugs, fantastic drugs, very expensive drugs. We really need companion diagnostic to get along.

Aging population, what does it mean? It means that there is more chronicity. What the pharmaceutical companies are trying to do, they keep us alive, but they keep us alive managing acute situations and trying to transform those into chronic disease, right? We need to take care of that.

Consolidation in the labs means more throughput because if you have 4 labs, they shut down, they open one. In all the major hospitals, this is what is happening. It means automation. And this is why if you go to a Siemens Investor Day, if you go to a Roche Investor Day, you see systems and engineering that is 50 meters long. This is the result of trying to address this, and we need to take care of this, also as a specialist. And in fact, you saw there, the LIAISON XL, the new instrument that Chen is going to talk about, which is increasing throughput for Diasorin.

Point of care, what does it mean, decentralization? It means that you need to go fast. So within 20 minutes, you need to provide a patient and a physician a diagnostic report. That's technology. That's the LIAISON NES that is €120 million and counting of R&D investments to get to that technology. By the same token, as said, there is no more money. And so, products that you develop need to really create value for the hospital and savings, and you will hear about that when Chen and Giulia will talk about what we do and why we think products in that way.

And last but not least, we really want to participate to the opportunity of precision medicine, but you know, is a complex…very complex sector. You need talent, you need know-how, and this is why I decided to create a division for immunoassay. I've been leading that business for 20 years. And we recruited talent. We recruited a young engineer

that joined from Johnson & Johnson, 17 years in Johnson & Johnson, and he knows precision medicine. And he came in and he's going to lead our effort to become a player in this segment, and you will see what we commit to.

So when you take care of this…when you look at these trends, now you need to position your products. So demographic shift, what does it mean? It means more cancer. We're not credible player in cancer, so we're not going to be investing in cancer. It means Alzheimer's. We're not credible in Alzheimer's. Too complex, too complicated. Roche and some other companies have great products on it. We're not going to play on that.

Diabetes, same story. Where are we going to focus? You will see autoimmunity, IBD, IBS, Crohn's disease, where we already dominate that market today, 70% market share, and hypertension that is certainly an area where again today we have specialty products and Chen is going to talk about it. So you're going to hear focused R&D expenses in 3 areas.

When it comes to consolidation, what do we have to say? The LIAISON XL. The new LIAISON XL we launch it in H1. It means that we increase throughput by 30%. So we…again, we will be able to play in this consolidated environment. 30% of our US business sits with very large commercial lab, Quest, LabCorp, ARUP. We are there already today, and we need to continue to follow what their needs are.

When it comes to value-based care, Giulia is going to talk to you about the LIAISON PLEX and the flexibility. So why do you need to have flexible panels, even if competitor are saying, no, you don't need to do it, Giulia will show you why you need to do it, right? And why mini panel is not flexibility, right?

Remember, when we said we will flex, first reaction of competition was, flexibility is not needed. After 6 months, well, we need mini panels. After 6 months, well, flexibility is very important, okay? So, what I think is great about Diasorin that we've been very honest about the trends coming, and we've been investing in those trends where we, I think, can continue to be leader.

Last but not least, precision medicine, 2 areas as said, hypertension and IBD. This is a very relevant concept, guys, because I'm talking to investor continuously, and I'm not clear if everybody understood who we are and what does it mean to be a specialist. So the way I see diagnostic is that there are 2 groups in diagnostic. There are the very large multi-segment companies. Great companies, great super companies, what are they doing? They're consolidating all the big labs, they're providing solutions…great solution for automation with 50 meters long stations that help the hospital to take care of growing volumes. These are what I call multi-segment leaders.

Then there are the specialist. They call themselves specialist, right? bioMérieux is a great company. Is a great specialist in microbiology, bacteriology, #1, right. Werfen is a great company, #1 in coagulation with Stago. In transplant, One Lambda that is a below Diasorin customer because they use our technologies, #1 in transplantation. OncoHematology, you have Sebia. These are companies that bet everything they had to be #1 in one segment, multi-technology. Specialist absolutely, this is not Diasorin.

We are specialist in a different way. We stands because we are leader in different specialty areas, and we don't care about the technology, and we don't care if it is inflammatory, if it is infectious disease, if it is diabetes, if it is hypertension, right? We bought technology, develop technology that allow us in one area where we're different, where it's complicated, where you need R&D, where you need to be global, where the market is not big. So if you want to make a difference, you

need to own 80% market share. This is what specialty means for us. Leader in different specialty areas.

What's good about it? If one day your specialty, as it happen with Vitamin D, goes from $4 million to $180 million in 3 years. And all of a sudden, the big company see that as an opportunity and they chase you; you're not one-trick pony. I remember the definition, one-trick pony. You're not a one-trick pony, because you have adjacent areas, where you continue to believe there and you grow into that.

TB is a great example. Everybody is not anxious about Roche shows up, and what is going to happen to TB? TB is an area where we are leaders, Chen is going to talk about it, we have a great partner, but it is not…we are not a TB company. It's part of a strategy. Okay, so I hope it's clear what does it mean to be a specialty today.

So if you look at the 3 legs, what can you say about it? Immunodiagnostic, which is going to be led again by Gabriele, is 130 products, a platform that we are just launching and market leader in different segments. If you look at molecular diagnostic, it's LIAISON NES, decentralized, respiratory opportunity where we are excited. We just launched this product weeks ago, literally. It means multiplexing, it means the flex concept in this new panel that Giulia is going to talk about.

LTG, great partnerships and opportunity to work with credible pharmaceutical companies, biotechnology companies to continue to follow them and provide them with our technology. So what do we commit to in this plan, right. Very pragmatically speaking, we are going to develop 20 new specialty assays. The vast majority of it is going to be in autoimmunity, because we want to be a leader in autoimmune. We are going to launch the LIAISON XL. It's going to be Q1 next year.

We will continue to be leader in TB, notwithstanding competition with QIAGEN, with Inpeco, you're going to see the program. You already heard about it from QIAGEN. We will continue to be the #1 provider in TB. And we will launch by 2030 one companion diagnostic, right. So stay-tuned, we are going to be talking about this.

In molecular diagnostic, what do we commit to? We will continue on the LIAISON NES to develop products. And women health is going to be the #1 priority for our R&D, while our marketing and commercial people, we are selling the respiratory products. Women health is going to be the #1 priority for this company. We will continue to develop PLEX.

Guys, trust me, the fact that last night the FDA approved GI, nothing to do with me. We got lucky, right, but we got the approval. Now, we have 4 out of 5 panels, right, as we promised, complete menu. There is more to do with that, with the PLEX. And then MDX, which is one of the most, I think, not understood platform we have, to be honest with you, but one of the most successful platform we have. We will continue to develop specialty products on this.

LTG, great partnership. There is nothing that we have to do. We don't need to reinvent the wheel. Let's follow what the great customers we have are doing and continue to provide services to them.

Said that, with great pleasure, I am introducing Chen Even. I have been working with Chen for 30 years. And he is going to be the one now leading you through for the last time for us, immunodiagnostic, because the next one is going to be Gabriele. Thank you, Chen.

CHEN EVEN: Can you hear me? I decided to go more rudimentary instead of having that high level. Thank you, Mr. President. I know you for 25 years. Thank you, Carlo. I know you for 30 years. Then people can guess how old I am, but don't go there.

Immunodiagnostic, one of our first divisions. My name is Chen Even and I am Chief Commercial Officer. And as people mentioned…Carlo mentioned this a few times, we have a new President for the immunodiagnostic division. His name is Gabriele Allegri. Gabriele, people heard a lot about you. Welcome to Diasorin. No pressure, no pressure. Everything I said, you will have to deliver, but if you want to say a few things.

GABRIELE ALLEGRI: Exactly, thank you. A great start. Thank you, Carlo, President Chen for all the trust on me after 20 years in the pharma side back in US, I decided to come back to Italy to take advantage of this fantastic challenge. If you have been working in pharma, I think you have seen the evolution of pharma space and you come to a stronger realization. But if you want to bring access to those innovations to patients, you need diagnostic. You need the right test at the right time for the right patient in order to identify a patient that can eventually access those innovations. And so for me, the move from pharma from US back to Italy in diagnostic was a natural step. But more importantly, the call came from Diasorin. And Diasorin is not a company like any other. It's a strong, solid, very innovative companies. You will see all my words here became even more clear after Chen. We go through the immuno division challenge opportunities and our vision there.

So thank you for the welcoming. Yes, no pressure, but it's a great future in front of us. I really looking for delivering this future. Thank you, Chen.

CHEN EVEN: Thank you. So as you can tell, the future is now. So we are the undisputed diagnostic specialist. We are better than anybody else. As Carlo said, pharma is here. So forget pharma. The IVD market is about 60 billion. But in this section, in the immunodiagnostic sections, how big it is. It is $18 billion per year, not so bad. And have many different clinical areas in which Diasorin is playing part of that.

So if you look at the pie, and you see that the sections which are colored, the infectious disease, hepatitis, retrovirus, bone and mineral, hypertension, stool, GI tract, and endocrinology. These are areas that we are already participating. It's about 40% of this pie. We are focused there. We are the diagnostic specialist in those areas. In the more boring gray areas, those areas that we by choice decided not to participate for various reasons. Either we are not credible, or the bar to entry is fairly high, or it is simply not our space.

On the other side, as Carlo mentioned, there is a space that we're going to enter, and that's autoimmunity. Using that space in green, and adding all the other colors, we will basically be in 50% of the overall immunodiagnostic market, as we the diagnostic specialists, are very fortified and very credible.

We have the largest menu…immunoassay menu, of all our competitors. 132 assays, if you count. But not only that, if you look at 2 different groups, one is what are the specialties, and what are the ME2's [ph]? When it comes to the high-volume specialties, that's what we do best, we score them 86 to 32. In football terms, will be like 9 to 3. If you look at the ME2 area, they score a 63 to 46. Again, in football terms, will be 3 to 2. So we are excelling, and we are increasing the gap between what we do best, specialties, and what they do, which sometimes is core ME2 automation. Which is…this is what Diasorin is all about.

Now, which products, moving forward, will make the difference for us? And I am going to go with 4 key products and tell you what we are about to do with them. Let's start with the first one, Latent TB. So TB…Latent TB, you all know 2018, we are sitting together with the good friends in QIAGEN, and we decide to put our efforts together. They have the tubes, we have automation, we put it together, and we built in a fantastic franchise in the last 7 years.

Now, let's talk about TB for a second. What is TB? 2 parts. You have the active form of TB. You are coughing, you're coughing blood, and if you don't get diagnosed quickly and get antibiotics, you may die. But there is a small portion of the entire TB area. The big portion is the Latent TB. These are people that have been infected. The bacteria is deep in their lungs. They don't show symptoms, but 10% of them would eventually show symptoms, will create cough, and will be very infectious. It's a very infectious disease and is a leading disease…infectious disease killing people around the world. There are 2 billion people around the world that are carrying TB. 2 billion is a third of the world, slightly lower. There are certain countries, but from those 2 billion, only 75 million are being tested on a yearly basis for Latent TB.

There are 2 ways to test for Latent TB. One is the more rudimentary, scratching your skin with a TB antigen, waiting a few days, coming back to see the doctor or the nurse, and then if there is a bump, you are positive, which means you have been exposed. If there is no bump, you're not. The more advanced one is basically taking your blood, putting the blood in 4 tubes, incubating, and then reading the results. And this is the one that we have using IGRA. More advanced, from the 75 million, 45 million tests are still done in the rudimentary skin test. And part of the things that we do with QIAGEN is moving those 45 into the IGRA testing when possible. Overall, the opportunity of TB is $1.6 billion per year. Big space, big space to grow, and we are doing and excelling, and we are #1 in that space.

The assays that we use today with QIAGEN is semi-automated. There is upfront bleeding, there is upfront work that is done on the tubes, then there is incubation and eventually going to the automated XL to do the readout. The ambitions that we have with QIAGEN, it's QIAGEN plus Inpeco, which is an Italian company in the art of

automation, plus our LIAISON XL, putting all these 3 together to put an end-to-end first-in-class latent TB fully-automated system.

While we're working on that ambition and we'll get there sometimes next year, you also may have noticed that Diasorin independently on the LIAISON XL have developed a new TB test, a second-generation TB test called the Gold Plus II and that test is giving you 25% faster results and 75% more patients per hour results. So, combining automation and combining the throughput, we are really in a position to answer the needs of our customers when it comes to consolidation at hospital plays an increasing need for testing.

Now, when you are successful, you get the barbarians at the door. You got competition coming after you. And we know you know that people are coming after us, people coming after this huge franchise. Do not worry. We know that they are coming, but we are well prepared. We are well prepared, because we know we have Class I assay. We are market leader and we have the right brand and the right partnership.

A few examples. Our assay have the CD4 and CD8 compartments. So, when you have a patient that for some reason, the CD4 compartment is not doing so well, in the case of HIV patients and no-compromised patients, we can capture the interferon coming from the CD8. That's an advantage. We are anyway market leader in almost all geographics and people know us, in many cases doctors, when they call for the TB, they say, I would like the IGRA QIAGEN Diasorin calling it by name.

The World Health Organization is recognizing us as the absolute gold standard for IGRA test, which is very important because in some countries without the WHO, you cannot get any business. And with time, QIAGEN is over 20 years in that, we gain on our assay many different claims that others and people that will join the crowd will not have it easier.

So, we have claims for compromised people. We have claims for pediatrics and et cetera, et cetera. So, we are well prepared. We have contracts. We have relationships. We have automation and we have all that stuff that is in this slide to be sure that when someone enters, we are going to make their life as hard as possible.

Gastro. GI track. What I call the blue, blue, blue syndrome. We are a leader, absolute leader in this blue, blue, blue syndrome space. We have it all, so you go to the doctor with the…with syndromes very uncomfortable and the doctor is looking and he is saying okay, it can be bacteria and there are various types of bacteria. We cover them. It can be a virus. There are various types of viruses. We can cover them. It can be issues of malabsorption's; something is wrong with your pancreas. It could be issues of inflammation. We have all. Not only we have all, we have in different technologies complementing each other.

As Carlo mentioned just last night, the FDA not by luck allowed us also to enter in the GI molecular space. And Giulia will talk a bit more about that so we have molecular and we have immuno complementing what we can do. And in addition, when a doctor finds you positive to one of those, he wants to know which treatment.

So, if you have inflammation, and they want to give you anti-TNF alpha, they need to test you for TB to make sure that you…if there now…there going to be immuno compromised, you would not be generating also tuberculosis, which is not a good thing. We also have that assay. We also have CMV. We have EBV. We have hepatitis. All of them will be important for the doctor to make a decision. Now so we have the menu.

It is also very clear that you need 2 things. One, you need automation. You need to bring it all together, and we do bring it all together. How

do we bring it all together? We have LIAISON XL with all the assays on top of it. And the second part, which is important is to continue generating more assays.

Here what you see is we are committing in this year and next year to bring 5 more exciting things to the game. The first one is the collection device. Now I stole this from Giulia. Thank you, Giulia, and that's why I have this in my pocket, this. So, if you go to a laboratory in a hospital, and you'll open the door and you go to the area when they are going to deal with stool. The smell is terrible. What you see there, you see all kind of cups plastic with a lot of fecal matter inside with all shapes and forms. Not easy for them to process, and not very comfortable. Also, if you think about yourself back home, when you had to basically generate that cup, it was fairly difficult.

This is the device. The device is very simple. You go to the pharmacy. You go to some center. You get the device. It's a tube. Inside the tube, there is a collection device. You basically open the tube, you do your business, you take it there, the sample, you close it inside, you go back to where you picked it, if it's the center or if it's the pharmacy, and they'll move it to the lab. The lab will take this one, they'll say "Oh nice Diasorin". They'll put it in the system LIAISON XL, they'll push a button and voila, they get a result. Much easier than the picture that was described before which is fairly messy and very difficult.

So, this one is going to be applicable for many of our assays when it comes to stool as a matrix. In addition to this, we're going to have the calprotectin second generation. The best calprotectin I'll talk about it in a second. Lactoferrin is another assay that is going to help doctors in case of inflammation. FOB fecal occult blood is the famous one that people are looking for blood in stool. Many times in…when you're suspicious of cancer in the colon…colon cancer and lastly, we will complete and expand our celiac panel. Good.

Calprotectin. IBD, IBS, inflammation, irritation. What is calprotectin? You hear this name a lot, but what is it? It's a protein. It exists in cells of the immune system. When you have this blue, blue, blue, those cells get into your gut and in this case, in your stool there will be higher level of calprotectin. If you have high level of calprotectin, probably you have IBD. If you don't have that, you may have something else and the doctor will take a decision. The numbers are outstanding because 5% to 10% of the population have irritations. Not a big deal, maybe you can manage that.

One percent have inflammation; you better see a doctor. And by the way, 10% of everybody that goes to see their doctors today, they go to see the doctor because they have some of the blue symptoms, so GI track issues. It's growing. It's growing because of age. It's growing because of lifestyle. It's growing because of diets. It's growing because of pressure. It is a growing business. It is a growing business and we are a market leader and we intend to continue to lead this market.

So, let's talk about what is the problem with recurring calprotectin and one we believe that our new calprotectin will be the best of the best. So, first of all some numbers. The incidences are 10 in 100, but the prevalence is 230 in 100,000. So, you got big, big numbers there, 7 million people are with IBD as we speak. Half of them are in the US, 3.2 million and those needs to be treated, a lifelong treatment.

What's the challenge? You go to the doctor. The doctor is checking your calprotectin levels in stool. If they are low, you're fine. He'll find something else. If they are high, you got IBD and I'll tell you what he is going to do with you in the next slide. But what if you're in between, the grey zone area? He doesn't know what to do. So, what is they say, why don't you go back and come in 2 months, let's see.

So, 2 months you're suffering. He doesn't do anything. I mean how many times you want to go to a doctor that tells you go back in 2 months. It doesn't work like that, right? So, that's no good. So, he tells you why don't we do colonoscopy. Well, okay, that doesn't sound even better, but fundamentally if he does know what to do, he does colonoscopy, which is expensive and uncomfortable.

What do I bring to the table? So, our great scientists, one of them sits in the room, I'm not going to mention by name, discovered a new biomarker. So, they figured it out, it's that when you do calprotectin and you're in their grey zone, there is another one, MMP8, wow. MMP8, if you do MMP8 after you did calprotectin and it's high, you got IBD. If it's slow, it's a false positive, don't worry about it, we can look for some other things. And this is the magic. The magic is that with calprotectin AD [ph], we are going to take a market which we already dominate to take it to the next level.

Let's look at the patient experience, once he doesn't feel well. He goes to the doctor. Now he's using our new IBD, IBS. So the doctor is sure if it's positive or negative. First, he does that. Now the doctor is no, and you need to be treated.

What does it mean? Let's change the diet, let's do a little bit more sports. Maybe we do some cortisone in order to alleviate the inflammation. And maybe we go to one of the biological, TNF-alpha. Okay, we test the tuberculosis and then we test TNF-alpha. Everything is starting to get better.

It's the right drug. You start to have lower calprotectin numbers, you're starting to feel better. You're going to feel better, you're going to feel better, but as I said, it's a chronic disease. Sooner than later, you're going to have a flare-up. And when you have a flare-up, how would you have a flare-up? You don't feel well, you check calprotectin, the numbers start to go up.

Numbers start to go up, the doctors now have choices. One, he's changing the drug. And this is where Gabriele said there is a new set of drugs which now will help.

Because the old first generation sometimes don't work so well. Sometimes people develop a resistance and there are awful side effects to some of them. So a new generation drug is coming in order to help the doctor relieve yet those symptoms.

And again, with calprotectin, you follow from the front all the way monitoring and helping the patients throughout the journey. So TB, GI, hypertension. I mean, hypertension is a big one. 30%, I wouldn't say people in this room, but 30% people around the world suffering for hypertension. There are different types of hypertension. One type is about volumes and one type is about restrictions. It's like pluming [ph]. Now, it is very important that when you have hypertension, the doctor will figure out what kind of hypertension before they prescribe medication. Doctors will tell you that most hypersensitive people take something like 5 different medication to manage their hypertension.

One of the known hypertension is caused by aldosterone. Aldosterone is a hormone. And when it's producing high amount and it's regulating the volume of water and salts in your blood, so you become hypertensive.

The problem is that you go and when you measure your blood pressure, the doctor doesn't ask you, why don't you go and check for aldosterone? So he subscribe [ph] drugs that may work and may not work. But look at the numbers. 0.5% to 2% of hypersensitive people, only those are actually measured for aldosterone. But the truth of the matter is that 6% of them do have aldosteronism, high level of aldosterone. And what we say is that 30% that have that are also the ones that don't respond well to drugs.

Numbers don't lie. As we go along, we're figuring out it's certainly underappreciated when doctors test for that. So the endocrine society have changed that. Last year, the endocrine society said, listen, there is enough evidence. If you have high blood pressure, the first thing you do, you screen for aldosterone, you screen for renin, you do the ratio between them and then what kind of hypertension you have and how to treat. This is good for Diasorin.

Why it's so good? Because we are market leaders in aldosterone testing in the world. We are market leader in renin testing in the world. And we're considered to be the gold standard for both assays and the ratio aldosterone to renin. So this is good. That means that now, if doctors actually follow the guidelines, the new guidelines, what can happen?

Let's talk about the best of the best. So if everybody follow that, the business of today, which is fairly small, a few millions, will go 25% higher. 50 million tests per year. Being more conservative and looking what happens with other types of guidelines, it could be 6 to 8 times more, still a very big opportunity for Diasorin. Okay? Another opportunity for Diasorin is assays, another opportunity for growth in the future.

MeMed changing. The ones that don't know, MeMed is a test. It's called MeMed BV, bacteria, virus. You get to the doctor, you could go to the doctor, you do a test, you want to know, does he have a viral or a bacterial infection so you know, if to give antibiotics or to give antivirals or just to send the kid home.

Fine, MeMed. What do we expect from MeMed? We learned in the last 5 years what works, what doesn't work. Let's tell you what we expect moving forward. So first, in the years 2026 to 2030, we expect

every year to add 50 new hospitals using MeMed. If you do the math, you do 50 times 5, you get to 250 hospitals or more.

The 250 hospitals that we believe by 2030 will be using our BV MeMed test. That will be about a third of our hospital installed base in the US, and I'll have a slide in a bit about how successful we are in the US hospitals. Now, we are basing those numbers on a few things that are coming up in the field with MeMed.

One of them is the Jupiter study. The Geno study already have been published, and what did it show? It shows that when you are testing, and you need to decide if to give antibiotics or not, in 50% of the time, when BV was used, they gave less antibiotics to people that had a viral infection, which is good. They had a viral infection; they don't need antibiotics.

On the other side, when they had a bacterial infection, 78% were given antibiotics, which is great. There were no side effects, there were no readmissions, there were no problems, there were no lawsuits, which means that for what we know, and for what we see in the market, all studies with BV with MeMed, all show the same thing, a tremendous value.

Now, to get a tremendous value into money, 2 things needs to happen. First, reimbursement, and then the payer needs to pay for it. So, what MeMed is doing is they submitted already to the CMS the request for unbundling, which means from a DRG, which is one price fits all, to get the BV paid separately. That will increase hospital usage because of the economy, and also some fee for service can be there.

And then the second one is dossiers have been submitted to almost all the private payers, trying to convince them that there is enough evidence to pay for all occasions when BV is used in hospitals. And we believe that when they're used in hospital more and more and more,

utility will increase and this business, finally will become as big as we believe it should be.

Okay, so we have the assays. We have the TB, we have the hypertension, we have the GI, we have MeMed, we have 132 assays, we are the diagnostic specialist. But as Carlos said, there is a trend, and the trend is automation. It's that hospitals that are having different rooms basically come together into the core lab and they need automation, they need throughputs. We are in this game again. So what was it, 2011, I had a presentation, I think it was in the Borsa, and I called the LIAISON XL our baby.

Back then it was the baby, but the baby grew up. We took the baby and refreshed it, and now we have the new LIAISON XL. And it's out there, beautiful white colors and the ones that passed in, can pass out. It's a beautiful story. It's flexible. We expanded capacity without expanding the footprint. Immediate access to the entire menu of the LIAISON XL. So it's like a past view. You use this system; you can use this system interchangeably.

Full compatibility with connectivity. So this system can connect to all the what we call TOL, Total Lab Automation. These are the big outfits that companies like Roche, Beckman, Abbott, Sysmex are putting, and traditionally we, with our specialty, connect to them.

So…and you got fewer steps, and I'll show you in a second, a much better walk away time. And we didn't leave the XL alone. We added accessories to it. 2 type of accessories. One is called the Auto X. And what the Auto X does, it allows us to, and it's there as well, allows us to take 2 LIAISON XLs and put them together.

What it does? Today, a LIAISON XL standalone, you can put 120 primary tubes in the system and then walk away. In this situation, you put 600. 5 times more. You put 600, you still walk away. The system

basically will align where each one of those tubes will go for best efficiency. That's one.

Second one, in the current XL, you need to use a wash buffer. It's a tank of 10 liters, its underneath. You need to pick it up and change it once a day. We listen to customers, we listen to what we need, and we basically put a device, it's the Dilute X. Simple system. You put the tank; you don't need to move it. It does all the exchange automatically. And it goes for 5 days, so pretty much once a week if the lab is working only 5 days. You have this and what you get bottom line: 50% higher throughput, minimum of 10 hours walk-away time, and the tank is good for 5 days. Can you ask for more?

Sometimes it's nice to toot our own horn. We did a fantastic job in the US hospital strategy, fantastic job. I'll show you the number, you'll be convinced. So, back in 2019, we looked at, what do we do in the US? Well, we did great in labs, commercial labs, private labs, but we are a little bit thin in the hospital space. That time we thought that the hospital space can be as high as 2,200 hospitals, we had 150.

So, we sat with the US team, and we said, let's put together a plan. Let's get more hospitals. Let's start slow. How about 50 hospitals per year? So, we put the first program. See Phase 1, 2020, 2022, 50 hospitals per year. Boom, job well done. We got it. We got to 300. Typically in Diasorin, when things are going well, you get a bit greedy. So, let's up the number. Let's make the 300, 600. In fact, Stage 2 was the next 4 years, let's get another 300. Boom, job well done. That's my time? I need more. Job well done.

And then moving forward, the next 4 years, as you can see, another 300. About to reach 900 hospitals, which will be, if you see, 40% of the total hospitals that we deemed can be reachable in the US. The future is now. Carlo mentioned autoimmunity, let me tell you a little bit about autoimmunity why we want to go into that.

The market is big, 1.3 billion. 45% of this market are the high volumes, but 55% are the specialties. You remember, we are the diagnostic specialties, number 1. If you look at out of that pie, €750 million are in this specialty space. And who is playing in that space? Well, you got Thermo Fisher with Phadia, you got EUROIMMUN, Revvity, you got Werfen with Inova, and then you got Bio-Rad. Reimbursement is not bad. The market is growing high single digits, and in certain occasion, in certain test, even double digits, so it's interesting. What's more interesting is that the trend of autoimmunity, part of the consolidation is as you see, in a hospital there are different specialty labs. In certain cases, those specialty labs congregate into the core lab.

And when it comes to the core lab, what do you need? You need automation, now interesting. The companies we dominate automation in the core lab, Roche, Siemens, Beckman, Abbott, none of them have autoimmunity. They are not the diagnostic specialist. We, on the other hand, we are there. 25% of our instrument, XL are connected to these guys with our specialty. So, if we bring the autoimmunity especially, it will go into the core, and we win. So that's our autoimmunity story.

Complementary diagnostic. Everything I know, educate me on, so precision medicine. Precision medicine fundamentally, companion diagnostic and complementary diagnostic, is redefining how drugs reach patients, and how every clinical dollar is being justified. It's the future. So, you got companion diagnostic, I think most of you know, for instance, I give you an example. If you want to give somebody anti-TNF alpha, you cannot give it to them without testing them for TB. It's a simple example.

When it comes to complementary diagnostic, it's more which patients will respond better to a certain drug because the drug is expensive, and

you want to stratify, no reason to put a drug that costs $30,000, $36,000 a year if you know the patients will not respond so well to it. So, you can choose another drug that will be better. The number speaks for themselves, so 40% of all FDA drugs approval in 2025 were already within the field of precision medicine, biomarker driven. 2 in 3 of late-stage pipeline drugs have a biomarker driven component inside. And 70% of the most advanced clinical decisions rely on results coming from diagnostics.

So, it's not so much the future, is the present, and based on that present, we are going to expand our research and our products in order to address that opportunity. Now, for most of you, I think for most people think about complementary medicine, the first thing is that cancer. It's true, oncology was leading. All the biological initially came from oncology. But the truth today the market is 50-50. There are already…50% of the biomarkers are not in the oncology space.

We, being humble, we defined 2 spaces that we are leading in, that we believe we can help by putting a diagnostic feature to support pharma. One of them is hypertension. So, it's fairly quick. If you need to measure aldosterone, and there is a drug that can minimize the production of aldosterone, they go hand to hand. Just tell me which company have the drug, the synthesis, and we are right there helping them in their clinicals.

When it comes to anti-TNF alpha, the same thing. Those drugs are old generation, new generation is coming out. If we are the market leader in GI and calprotectin, and this is a drug that use mainly for Crohn's disease, which is fundamentally measured by calprotectin, we can be at the front edge of those drug development. So pharma and diagnostic is part of our future.

Last slide. Key takeaways for my presentation being diagnostic, 7 dots [ph] around. Let me start with the one up there. No doubt, we are

strong, we are the diagnostic specialist, and we play in a large field of 18 billion, in which 50% of that we can claim to have products in, that's number 1. Innovation, our kits always take innovation, and this innovation also bring differentiation, so, I take the bottom and then go back to the top, innovation differentiation. Technologies, when you have so much innovation and you have so much differentiation, you need automation. We have the XL, we have the connectivity, we have the ability to go to the core lab with our messages.

We are giving you visibility, long-term, the future of the future. We are going into autoimmunity, and we are going to bring in the precision medicine house. We show you that in the US we are doing great, and we continue to accelerate in the hospital penetration, not only with immuno, Giulia will show you, we are also going with molecular to the hospital business in the US.

Clear execution. So, our commercial team, our team Diasorin, number 1 in latent TB, number 1 in gastro, number 1 in hypertension, and we will be number 1 in MDx.

So, I will stop now, and I will surrender the podium to the good people from molecular, the President Angelo Rago, and VP of Global Marketing, Giulia Amicarelli. Thank you very much for your time.

ANGELO RAGO: Okay. I don't know if I can follow Chen as well. Oh, thank you. All right; I have a couple of opening comments I want to make. I might be a little bit more tactical here and read them because I want to make sure I bring these key messages across. First of all, today we want to share an update on the molecular diagnostics business and the strategy we've been executing. It's been anchored in understanding emerging needs in healthcare, and delivering diagnostic answers that matter. You're going to hear this strategy presentation. Today and into the future, not just today, but into the future, we will continue to cover

what we are seeing in the market and how we're going to execute and what we see as the opportunities ahead.

As Chen mentioned, Giulia Amicarelli is the Vice President of Global Marketing for the Molecular division. This is her 20th year with Diasorin, and I tell you; I value her expertise every single day. Giulia will walk through the portfolio and how it's positioned competitively, and I will cover the strategy and priorities.

I want to make a personal comment because I'm not…I didn't grow up in IVD like Chen and Carlo did. I'm actually in the industry for 40 years, 38 in medical technology. In that time, I've been part of some very strong companies, I have to say. But I have rarely seen the level focus and pace of execution we have in Diasorin Molecular today. And I say that proudly. Since 2021, the track record has been difficult to match by our competitors in our industry. And a clear example of that is yesterday's GI clearance of PLEX, GI. This is the 11th clearance for Diasorin Molecular since the acquisition of Luminex. I think we should pause on that for a minute. 11 clearances. I don't know why Carlo still gets a question about Luminex acquisition. It's clear. It's absolutely clear and you will see it in our presentation today.

I am proud of our team and the momentum we are building. We are building a molecular diagnostics franchise that is differentiated through innovation, alignment to evolving healthcare needs and backed by disciplined execution. And by the time Giulia and I conclude, my goal today is that you all have a clear conviction in Diasorin's ability to compete and win in this segment for the long term.

So let's go. First slide. So Carlo talked about the trends, healthcare pressures. I would like you to read this left to right because it's really important to understand successful companies create value by understanding the problem to solve. Not by creating technologies, but really starting with what is the problem to be solved? You heard Chen

cover it for immuno. Let's think about it in molecular, the aging population, rising chronic disease, increased demand on what the market dynamic is for molecular is increased demand of complex diagnostics and targeting on patients.

What do we do? We target highly specialized testing, diagnostic specialists, consistent value-based care, really a strength of our portfolio. Diagnostic stewardship clinically is where things are going. It's connected to value-based care. Diagnostic stewardship is a main theme in molecular.

What is our solution? Flexible and customizable diagnostics tailored to the needs. And you are going to see a video today, which will even exemplify this topic. Value-based care and spending pressure, diagnostic stewardship, workforce shortages, simplicity, automation, and flexibility. You see that with our platforms out front. We have got automated, streamlined operation and care decentralization and point of care migration, the speed of decision-making, the data integration, all with the cloud for NES, fast diagnostics connected with analytics, fundamentally the next generation in point of care.

Why do I say that? So let me take a minute and I showed this in the last Investor Day, but I think it's super important to understand how we break down the market. We just don't look at molecular diagnostics. We look at it from the context of throughput along the x-axis and multiplexing on the y-axis. Now, this area over here is not in our range, low-plex, high-volume. This is where Roche and Hologic might be. That is not in our space. We have broken the market down in what we call 4 quadrants. You have batch testing, more to the right, and on-demand, more to the left.

Our platforms are specifically tailored for the segment we are in. And the reason for that is because you have different settings. You have different settings and you have different patients presenting in those

different settings. So you know, if you have a hammer, everything looks like a nail. That's not what we do. What we do here is really develop technologies and platforms that stem and address the needs of each one of these segments.

An important part here is the global market for IVD is 14 billion. Syndromic globally is roughly 3 billion, and targeted testing is roughly 11 billion. Now, the important part is the US represents roughly 45% of the global market. So we are going to be shifting into a US view here in a moment, just to point out that the EMEA and rest of the world represents roughly 25% of the market.

So what is important here is that in the United States, there is a growing strength of IDNs, right? Integrated Delivery Networks. And this is really systems being built with hospitals, clinics, urgent cares, and offices. And I will talk about that a little bit more in a minute. What you see here is 10,000, 30,000, 183,000. Those are the location numbers. Okay? So those are the number of locations. And they work in a hub and spoke model. You typically have acute in the top and non-acute in the bottom. Right? And so work is moving.

The complicated cases are really being captured up here at the top, and they're trying to move as much routine down. That's because of shortage of resources in the hospital setting. But also, you've got an aging population. If you've got chronic diseases, they're filling hospitals. Right? So even in my old industry, what you saw is complex surgery stayed in the hospital. Routine surgeries moved out of the hospital. So there's that trend happening right here. And you will see, and Giulia will show you, how our products plug into that market and why we have strength.

So what's happening? Physician's offices are being purchased. And this is what's growing down here at the bottom. Now, something to understand, there's roughly 900 IDNs in the United States. What we

haven't seen yet is a broad standardization. What does that mean? The decision for technologies here in the POLs is still a rather independent decision. There are some who have standardized. What does that mean? Corporate makes the decision what the platforms are, and then you go deploy that into the arteries of the organization. That's a rarity. But if you think about where cost in the United States is, where the challenges are in healthcare, there's going to be a need to standardize. And you will see in Giulia's presentation why we have the best solution for where the market is going to go.

Now, if we speak about this non-acute space, we tried to show you here, there's roughly 4 million tests in the acute space and 26 million in the non-acute. That's mainly because you had to have admissions. So something like the NES can fit really well in an ED, where maybe you have a baby come in, is at RSV, they want to evaluate very quickly, and so they can use that. But mainly, you see 26 million tests in the non-acute space, and a lot of that is conversion from antigen to molecular.

The respiratory molecular market grows at roughly 5% per year. In the segment of POL, it's growing at 10%, and it's mainly because of this conversion and the movement of patients into the non-acute space. What's important is IDNs, the network is a reason, they want to capture patients, right? If they capture you down here, then you are part of their network, you are in their system. And so, when you need to go to the clinic up here, or for a minor surgery, you are captured. When you have to go to the hospital, you are captured. So the intent is really to keep you in their system, because that's how they're going to make their money.

Alright. So that is the high-level strategy for molecular. I am now going to turn it over to the smartest person that I know, so she can take you through the products in detail. Thank you.

GIULIA AMICARELLI: Thank you. Hello. So can you hear me? Yes, now yes. Thank you, Angelo, too kind. So the technology that you have seen from Angelo represented in the quadrants, they have a very specific positioning when you look at them in the context of those IDNs. So it's counterintuitive probably, but NES really fit the position of the acute space when it's in emergency department within the hospital, in wards of the hospital. So where any time, let's say, there is the need for a very quick decision. The patient is in emergency room, has to be isolated, where do we admit them? So that's where NES fit very well. At fit, obviously, is actually designed to fit the non-acute, because that's where the majority of the market is for the decentralization trend.

In the acute, which means, again, in the hospital segment, we, of course, position both PLEX and MDX, MDX plus, for all the more complicated cases where there is a high clinical value decision that needs to be taken, okay. So we will see that this is important for a couple of reasons. First, how we are going to go to market, especially with NES. And second, because there are opportunities to propose solutions that go beyond the product into a more comprehensive solution, when those piece of platforms really can offer on a clinical side solutions that are more comprehensive.

So let's start from the NES we will go to the PLEX and finally to the MDX. That's the core of the presentation. So the LIAISON NES, we got clearance at the end of vertically December, and that's our very first CLIA-waived platforms. CLIA waived means it's designed to be operated outside of hospitals typically in physician offices, urgent cares or clinics.

The first assay that we have currently on the market is our Multiplex assay. That's differentiates…detect and differentiates the most common viruses that circulate during the winter season, Flu A and Flu B RSV which is extremely important and COVID. We have a second assay still falling in the category of respiratory that is the Strep A, that

is currently with the FDA and these 2 are basically covering the…all the respiratory applications, so it's the portfolio of respiratory. We are already working for the next wave that will come and will be dedicated to women health and STI. We'll talk about it a little bit today.

So, many of you asked me, so what's the different of NES versus all the other platforms that exist out there? There are not that many. There are 4. So, I need to explain these and I need first to say that we had a very unique opportunity, thankfully it was unique, which was to design their requirement for this product during the COVID pandemic. You all know that in that period, those decentralized testing did happen dramatically. So, we've really had the chance to learn about it.

So, we learned…if I had to simplify, probably 3 things. First, the solutions out there were good, but had some gaps. Some of them were for example very fast, but completely lacking multiplex. Now you need to do many tests for the same answers. Others were multiplex, but very complex to operate. And others were very easy to operate, but very slow 30 plus minutes for an answer. So, that gave us really the opportunity to say, okay, we had the chance to design something new, let's do it right, based on what we are learning.

The second thing we learned very soon was no, we cannot take our MDX and make it CLIA-waived. This is not going to solve the problems. We need to design something very specific for this space, otherwise you will have a half-baked solution.

So, the third thing was that this segment is so different from what we're used to. We need to make the experience very streamlined. So, we really mapped the customer journey, how can we make it easy. How can we make a medical device feeling like a consumer product? So, we ended with a solution that is very, very easy to use.

The ordering is easy, the contracting easy, the go live is very streamlined. We provide all what is needed, so customers don't have to think about procuring sample collection device. Procuring controls, everything comes with them in a very easy way. It's very fast, about 15 minutes, but most importantly the setup is done in seconds, so, really easy.

It's multiplex and because it's a modern instrument, we of course could implement connectivity that is a modern connectivity including Wi-Fi, cloud. They're really streamlined again, for example the upgrade of software give all the visibility into analytics, gives extra information for certain type of customer. They want to see beyond the simple positive or negative. They want maybe to see CD curves, things of that nature. So, we really did something that of course was portable and compact and that really was designed for that space, without compromises.

So, if we want to compare this with the competition, again depending by the competitor, we may be much smaller sometimes even 10 times lighter, complete room temperature. Someone does need refrigeration for example, and most importantly it's really, really easy, does not even require any interaction with the graphical user interface. The test is starting to multiply for example. Amplification time is fast. There is some that is about only 30 minutes, it is multiplexing and once again we have put through the cloud some other features that are very unique to us, right, to make this system even more valuable beyond just the reagents and the product.

So, when it comes to its positioning, we had discussed has a position in acute space and in the non-acute space. Now the way we are now focusing is on the marketing commercial side, in execution of a commercial strategy, on the R&D side, on the expansion of the menu.

We have signed agreements with 2 distributors. As you know, they will help us as a multiplier force to propose the NES in the acute space whereby the way certain aspects of the product are more relevant. For example, this cloud features that I mentioned into the non-acute space that is very big. So the multiplier force of distributor [indiscernible] is the way to go.

So, we are now, of course, in this execution phase commercially while as we said, we are working on the next wave, next portfolio that will come in the future, that is really focused on STI women health where NES can really, really make something good. The problem here is that today this kind…the diagnosis of those kinds of infections is really made centrally. So, samples are collected, sent to central labs and this take time.

So, obviously the fact that this take times result in a couple of problems. First of all, the patient loss, about 40% of those patients rarely go back and so are lost. Then there is of course a theme of overtreatments, so because of the problem antibiotic are prescribed empirically without knowing really what is the diagnosis. And so, this translates into a quite high number of cases of STI and vaginitis that is increasing year over year at a very high pace since few years already.

So, it's a sort of a very critical health emergency and so, imagine being able to offer to all those type of locations gynecology, STI clinics, urgent care et cetera. A system like this that during the visit can immediately say what's the problem, that drives the treatment is really where we see a perfect fit for a system like this.

The market at the moment is about 1 billion but it's mainly centralized. The centralization is still tiny because it's very much driven by availability of technologies that is very little still. It is about 200 million as we speak, but it's growing about 15% year over year, so that's what makes this attractive and we foresee that amount, that

opportunity migrating from a central to a decentralized location for diagnosis.

So, the LIAISON PLEX, that's quite exciting and different positioning, but we will see there is some synergy with the NES that we can tell you. So, first thing of all, the last Investor Day, we didn't have the system, so we did a lot of progressives then. We have launched, as you can see, 5 different panels. Particularly 2 of them, the respiratory and the gastrointestinal are fully flexible and customizable. We'll talk about it of course and then we have 3 panels for blood culture. Basically infection of the blood may result in sepsis. And those are also to us flexible in the sense that we have decided to develop 3 products that are really dependent by the Gram stain so that we can offer something very appropriate.

So, all the concept around the PLEX is the clinical appropriateness, because this is where the healthcare assistance and IDNs and all the big trends that we have discussed today, that's what is needed and will be needed more and more. Do a responsible use of the test that really create value and eliminate redundant testing or repeated testing that have a cost, but don't bring value.

We have in development another test for the meningitis. Still also this one is flexible and we'll touch a little bit about beyond this in a couple of slides. This market is…and the positioning of the NES and entire syndromic market is really high beyond the acute space. It's 1.2 billion, growing about 5%. And that's where the dynamic are really interesting to understand. We have seen and we keep seeing some significant pressures that are in some way modifying the way syndromic is done. The first and one of the most important, I would say 2 out of the 3 are the most important.

The first one are the financial reimbursement challenges. So it's very well known that payers have a very clear opinion about the use of very

large all-in-one panels. And so, they see the utility of those panel in very specific clinical cases where the patient is truly severely ill. So they don't see, and they are basically denying reimbursement for cases in which this is not the case and where a more targeted approach is more appropriate.

One of the last example happening in the State of Alabama, when one of these big insurance company, again, has enforced this policy to really cover based on the severity of the patient smaller versus larger panels. So this is of course, something really important and the competition is reacting to that, launching most little bit smaller panels, okay. So we'll see how that plays into this discussion.

And then there is the clinical pressure. So diagnostic overuse, stewardship, there are many, many stewardship committees in those hospital. They really sit down and design and discuss what is the right test for the right patient that we should utilize so that we can get the maximum value out of it, and we can prioritize this testing over testing that is less valuable. So we can use the resources in a responsible way, get out the best from that without waste. Okay, so that's where I think PLEX is the solution that really enable those kind of reasoning.

And why? Because that's the fundamental differentiation of PLEX. So all the syndromic technology that we find on the market, they really come with those defined panels, they are fixed. So the manufacturer decides what's the composition of those panels. They have usually a very broad coverage, which is really good for immunocompromised. But of course, becomes overused or unnecessary for a number of other clinical presentations.

So LIAISON PLEX has this ability to offer customization and flexibility. So now is the user, not us, who decide what are the pathogen we want to test, because that patient is a child or that patient is an immunocompromised because it's winter or because it's summer.

They really do the right thing that is more appropriate to what is the clinical presentation. And therefore, they can pay in a way that is proportional to what they're testing, and really create the value or assign the right value to that test. So this is the unique differentiation of PLEX.

And I want to give you just one concrete example of one of our customer. In this case, it's a primary US hospital system. They have…this is the acute space, right? So they have standardized in this case. They have an hub and spoke with a total of 7 hospitals. They decided to implement PLEX and they designed exactly those panel here represented. You see they've designed, the cartridge is always the same, but in the same product is like having multiple products, if you think. So they've designed a full panel for the more fragile population. They designed a really interesting panel, I want to make you notice, that does have everything with the exception of the 4 viruses that we have discussed with NES.

So this is beautifully applicable if that patient was tested in emergency department and was negative, why repeating the same viruses? There is a more seasonal, smaller panel. And look, there is a panel for pertussis has such a particular symptoms. So it's very targeted approach and the bacteria. There've been outbreaks of mycoplasma. We know there is an outbreak, why we need to test for everything? Let's test for the mycoplasma.

So that is a concrete example of an adopted customized panel that have enabled diagnostic stewardship in that hospital. Now, because I can tell you those stories, but I'm sure is much more meaningful for you to hear from a real customer, how they see the diagnostic stewardship and the flexible testing. We have recorded an interview to Dr. Morgan from Cedars-Sinai in California. She was interviewed by our Chief Scientific Officer, Dr. Michelle Tabb. And so I like to show the video

to you so you can hear directly from an expert, the concept of customization and its value.

MICHELLE TABB: We are at Cedars-Sinai Medical Center here in Los Angeles, California. And I'm joined today by Dr. Margie Morgan, who is the Medical Director of the Clinical Microbiology Lab and a clinical microbiologist by training, as well as a Professor of Laboratory Medicine and Pathology here at Cedars-Sinai Medical Center. Maybe you could start off by telling us a little bit about the patient population that you see here at Cedars. And also that, of course, those testing's come into your lab.

Certainly, I've been at Cedars a very long time. So I've seen a change in our patient population over the decades that I have been here. Over the last decade or so, we have seen somewhat of a major change in our patient population because some of our nearby hospitals have closed. And so, we're getting a little bit more of the general medicine population than we used to see, not so much just transplants and upper-level cancer care and such. So it's been a very interesting time. We also see outpatient testing. Our ED has been very, very busy over the last few years. And we also have a reference laboratory here…over here at Cedars. So we get a good cross-section of people, but far more general medicine than we used to see as of a decade ago.

GIULIA AMICARELLI: Okay, interesting. And obviously here in the laboratory, you have tremendous access to a lot of the latest technologies to serve these patients. So I wanted to hone in a little bit more just on a particular technology, and that is the syndromic multiplex molecular panels. And let's talk about that for a moment, just about a lot of these broader panels, because there are several on the market, lots of targets that are included, and sometimes you have to take what's offered and test all of those targets. So can you touch maybe about how a large panel like that can pose a challenge for you when you're trying to test these patient populations that you do?

MICHELLE TABB: Certainly, large panels can be useful possibly in certain situations. Perhaps if you have a very, very ill child coming into the emergency room and being admitted. But for the most part, when you're using these very large panels, they tend not to really follow our stewardship guidelines at all. They're not targeted in a way that really makes for the best medical care. They're very, very broad. And by being very large and very broad, they're very expensive panels.

And for this day and age, they're not being reimbursed. So if you have patients that aren't adequately insured, they're going to get a pretty pricey bill from us using these panels. So over time, we found that it is much more advantageous to try to flex test and use smaller panels to meet the stewardship needs of our hospital, to improve antimicrobial use, and also to meet better needs of our patient population, not just for medical care, but also for their financial needs.

GIULIA AMICARELLI: Okay. So you already mentioned FLEX testing. And so now let's talk about LIAISON FLEX and flexible testing, because you've decided to adopt our Diasorin system, the LIAISON FLEX here in your laboratory for respiratory testing, as well as for blood culture testing, right? So can you talk about how that has been a solution here for FLEX testing? And then also maybe how you use that to drive some of your stewardship initiatives?

MICHELLE TABB: Oh, I think that we've been very long users of FLEX testing. It was a very interesting story that I can relate to you about how normally we've, decades ago…2 decades ago, shall we say, we were just developing tests, moving along as we thought we needed. And very seldom had anyone contacted me about possible misuse of tests. And…but when we were using these very, very broad panels for respiratory testing, I did get a call from administration asking us if we couldn't look at another solution. They were costing us so much money as our volume in testing was increasing.

And so, that's when we looked at FLEX testing many years ago with the VERIGENE system. We were one of the first laboratories in the country to move in that direction because we needed a less expensive solution, not just for in-house costs for the laboratory, but also for patient situations. We were getting patient complaints about billing on some of these broad, big, large panels because they weren't adequately insured.

So we thought [indiscernible] way for many ways of improvement to move to FLEX testing. Administration would be more happy with us, because we're looking more at the financial aspects of the laboratory. Stewardship would be more pleased with us because we're moving toward a more focused approach, and our outpatient, possibly not very well-insured population, would be happier because their bills would not be as large as the ones in the past.

So it just seemed to work for us. And so, we started many years ago, I lost count, 15 years or more ago, and continued it ever since because it worked for us in our patient population.

GIULIA AMICARELLI: Okay fantastic. So related to this an your patient population, it sounds like you have quite a bit of history, right, with administration, them asking for a solution, and then having one here, not just in Verigene, but even in LIAISON PLEX today. Can you share a patient story with us about how this has had some direct impact, just the clinical utility or clinical care of that patient, but also maybe hitting their pocketbook a bit?

MICHELLE TABB: Yes. Well, we do, as I said, a lot of outreach testing, also testing in our emergency department. And a lot of those people, as you were saying, it does hit their pocketbook because maybe they're not adequately insured. But also sometimes the people will come in or be…and see a pediatrician or someone in our emergency department, and they have

very directed testing that they need, such as they need to rule out Bordetella infection. Or we had an ongoing issue with Mycoplasma pneumoniae in our area. And so they don't really need a very, very broad respiratory panel to look for these very targeted clinical cases.

So the last one I remember was, a mother and small child came into our emergency department with a very chronic cough. And one of their other…her other children had been having a very, very bad cough for a couple or 3 weeks. So they came into our emergency department, and of course our pediatricians were immediately on guard for possible Bordetella infection. And so they didn't really need a very, very broad respiratory panel because they were kind of targeted in what they thought was wrong with this child.

So, we offer a limited, a target less than 5 targets, that include Bordetella testing, and so we were able to do very rapid in-house testing that was targeted, that met their patient needs as well as their financial problems, and offer a solution. And sure enough, both of these patients had Bordetella pertussis. Because in this case, there's a clinical mismatch, right because there's a lot of viruses on the panel, but then pertussis is usually caused by the bacteria.

GIULIA AMICARELLI: A very…yes, a very chronic, whooping cough.

MICHELLE TABB: Okay. In this case.

GIULIA AMICARELLI: That was in the child, because it was a young child around 6 months of age, very, very ill. And so it provided a very rapid, targeted diagnosis, and so we thought we were being very helpful for that the correct and targeted diagnosis of this child.

MICHELLE TABB: Okay. Going a little bit deeper into the clinical aspects here, I also wanted to flip this to when, we use these larger panels that have lots of targets on them, but maybe when something is really, really low

prevalence, and so the positive predictive value might be low and you could get a false positive. What could happen there in terms of maybe isolation costs and things like that?

GIULIA AMICARELLI: Yes. Well, we always thought, even when we were using the very, very large broad panels, it was ridiculous to be testing for influenza and RSV, and these, you know, viruses with known seasonality in August. And in charging someone for this unreasonable testing. And so, you weren't doing any kind of targeted testing to begin with, and you are right, when you have very, very low prevalence, you're more likely to have some false positive reactions. So you could have issues in that as well. And so that's where if we can use FLEX testing with seasonally directed panels created you really provide better care all around, better sensitivity, specificity, just better care.

MICHELLE TABB: Okay. And you mentioned the smaller panels, but with flexing, you could also adjust like when there's an outbreak or even have to type or sub-type. That brings up a very interesting issue. I'm in cow country. Yes, and so we have cows just on the other border, of Los Angeles County. And so, we've had a lot of issues with H5N1 the possibility of it coming into LA County and coming into our hospital. And because of that, Los Angeles Public Health Department has required us to type all of our influenza A's for the last season.

And so, we made a FLEX panel with all of the subtyping through on the PLEX. And so, when we had Influenza A detected on the PLEX, we could just open up the FLEX panel and see what type it was. So it was magic, it worked so well. And thank goodness we did not have any H5N1 in our hospital, but because we were able to type all as H3 or H1, it was very, very helpful to LA Public Health Department and also our hospital setting.

GIULIA AMICARELLI: Yes, and reassuring, too.

MICHELLE TABB: Very reassuring that H5N1 was not spreading into our population. Fantastic.

GIULIA AMICARELLI: So Cedars has been here for a while, and the hospital has grown, and its footprint has increased, and the patient populations that you have served have also changed a bit. And so, how has FLEX testing enabled you to serve those different patient populations better?

MICHELLE TABB: Yes, I've been here a long time, I've been here for 40 years. And I've seen the growth and the change of Cedars over that time. When I first came here, we had a very, very small pediatric population, mostly pediatric cancer and some admissions from the ED, but very few pediatric functions or services. And then over the last decade we have a new developed children's center here at Cedars, so we're seeing far more children admitted to Cedars, offering a much wider and broad services and surgical services for children. So we have worked with pediatrics in increasing our testing in all areas, not just respiratory and blood culture, but in many areas. And it certainly went into reviewing all of our FLEX panels on the PLEX system and making sure that we were meeting the needs of the pediatric physicians.

GIULIA AMICARELLI: Okay. Interesting. So that leads me to ask you more about the metrics here, because you kind of just mentioned it with your hospital administration, too. So it sounds like some metrics might actually be driving you more towards flexible testing. Can you just talk about that a little bit?

MICHELLE TABB: Certainly. I'm not directly responsible for all of those analytics, and I'm so glad I'm not, because it's can get to be very, very complicated but I do have a business manager associated with our laboratory, and he very much looks into all of the data analytics, the test usage how much labor is involved in those tests as well, and how they are being reimbursed to the medical center. It's all very, very important data. And so, we have been very grateful that by using the PLEX system, it

is being reimbursed. And so, our analytics have been positive. And I've not received any of those calls from administration over the last few years about we're offering tests that are not being very well appreciated by our patient population because of cost, or driving up the costs in our laboratory as well.

GIULIA AMICARELLI: Okay. So it's really helping on a lot of different fronts. Clinical utility being able to deliver what the physicians need for a particular patient, so personalizing the testing, and also helping the bottom line.

MICHELLE TABB: That's right.

GIULIA AMICARELLI: Okay. Fantastic. One of the last things I wanted to ask you about was sort of a forward-looking. So as you know, we have our flexible testing for respiratory, and we also have our blood culture panels that you…

MICHELLE TABB: Yes, I wanted to mention about the blood cultures in that…we've also find that it's very cost-efficient and directed to use the PLEX panels for the blood culture testing as well, because by offering separate panels for the gram-negative infections and the gram-positive, it's half the price of the panel, the broad panels that put the 2 together. So to offer the same services, the same resistance markers, the same identifications, we can do it for almost half the cost by just having the initial step being a gram stain. And so that has also been very cost-effective and helpful to the patient as well.

GIULIA AMICARELLI: And also probably increasing that yield of positivity, let's say, because you already know it's gram-pos or gram-neg, and so then immediately you're running that directed panel.

MICHELLE TABB: Yes, very much so.

GIULIA AMICARELLI: Okay. Fantastic. And what about GI testing? It has some parasites, some viruses, and some bacteria on it. And so, what are your thoughts about a panel like that and its utility for patients, like maybe summer versus winter or travel history et cetera. Certainly, well I do think that like respiratory track you can have specific symptoms and travel histories and epidemiologic factors that can lead to the thought process of which stool group that you are going to…pathogen group you are dealing with. Parasites are unique and such. Viruses have more different symptoms possibly than a more chronic bacterial infection. And so, I think having a FLEX panel for such uses could be very, very helpful, and once again lead to less laboratory costs and less costs for the patient and give you a more directed focused solution to what's wrong with the patient?

MICHELLE TABB: Well, thank you so much for joining us today. The information you've provided has been fantastic. Thank you for being a customer for so many years and a great collaborator too. We really thank you for your time this morning and yes, it's great talking with you. Thank you very much.

GIULIA AMICARELLI: So hopefully it was clear the value of customized testing in this particular case and the last point of the interview was about GI. So I want to tell you that if the concept resonate with you on the respiratory is even more relevant for GI. So on GI the kind of…this is…this represents just the result of a survey of over 100 laboratories that we did very recently to prepare for the launch of PLEX GI and really the message is, it's very, very rare. It's basically never happened that the full panel for GI is necessary.

So here you see based on clinical presentation like hospital acquired infection, pediatrics, foodborne, that really a different composition of pathogens that are considered relevant. There are core 6 that are recurrent, but then you will notice more viruses that are relevant for children, parasites for travelers. It's really, really resonating with the

concept of clinical utility. And so, exactly for that reason, I want to mention our competitors did launch recently smaller panels, 11 targets and…but the point is they decided what those 11 are. So the real difference with PLEX is that if we want to choose an 11, 11, 11, and 11 is the name of the pathogens that combine the composition of that 11 that is the true value here.

I also want to mention just for your information that our product also have 4 more parasites than any other product and are quite rare but very difficult to be diagnosed today through microscopy and remember staff shortages and et cetera. The beauty of PLEX is that we can include rare pathogens because we know that people may avoid to test for them unless it's truly necessary. Now it's valuable, right?

So in this graph it's a little bit complex. I want to spend 2 seconds to show it to you. Why the type of pathogens is more important than the number of pathogens? So if we consider 11 that are fixed for our competitors based on the clinical presentation, is that foodborne, is that pediatric, is that hospital acquired, the efficacy of that panel which is now colored in those, kind of, oranges may really depend by what are the 11. So certain panel may be really good for foodborne but are not that good for pediatrics because it's 11. So now you need to define what to put in the 11. If you put just one virus it will be not perfect for a pediatric.

So the very same concept where on PLEX we can decide what are the 11. Those 11 for an HAI patient are not the same 11 of a pediatric one. So the effectiveness of these 11 is much higher. Now you want to go higher than 73 you can run 15 instead of 11. It's the core of the differentiation of the PLEX.

With this said I want just to mention very quickly, because I mentioned it before that PLEX and NES can coexist very beautifully in the acute segment particularly exactly because PLEX is customizable and

because we run the entire clinical trial of NES comparing the results with the PLEX. So we can say the 2 platforms are substantially equivalent. So if you are testing your patient emergency department is negative, you need to do a second line testing with a syndromic panel. You can do it avoiding to repeat the 4 you already have done, right with the confidence that the 2 platforms are equivalent in performance which now start to give us the brilliant opportunity to propose solutions beyond simply products.

And finally, the MDX plus it's the new generation of the LIAISON MDX, Carlo has mentioned have been a solid platforms for us. In this case the menu is the one that we are migrating to in the MDX plus and the real core of this segment for us is specialty. This is an example of 3 of the latest specialty testing's that we have which means we are the only one having them. They are growing really well because they are filling a gap. They are the novel, they are unique to us and so the philosophy of specialty testing continue and will continue.

So what's the future? We are really looking into specialty testing application that clinically emerging fungal infection vector infections so infection through vectors and genetics. So all area where we can be specialists and where flexible testing is also valuable.

With this I am ready for the conclusions.

ANGELO RAGO: Okay, I am wrapping up molecular now. I want to bring you back to the video for a minute. Did you hear Dr. Marjorie Morgan state it was magic related to FLEX testing and the situation she had with those patients. The other thing I want to refer to is she talked about meeting with the pediatric physician targets and that's an important part of FLEX testing, because the lab can look at their historical data and from this, they can create potential new panels, but they work with their physician colleagues to ensure that those panels meet the medical need.

So this is really, really important for us to understand the value that FLEX brings.

And the other thing I wanted to make a comment on because I said standardization was slow. The networks, Giulia talked about the example where they were standardizing. They are standardizing at the hospital level. She talked about a hub and spoke 7 hospitals one of our accounts, where they're start to standardize is at the core and they will take time to move out, but we believe that that's where the market's going to go is standardization through the whole network based on cost management and in giving the highest clinical value.

So I hope we've been able to convince you, Diasorin is executing on the strategy that provides the right test for the right patient in the right setting. Diasorin is the leader in syndromic customized testing and ultimately again the diagnostic specialist idea. A custom panel is a specialty right, because you are specializing it for that specific setting. Technologies are tailored to the segments without compromise. The combination of these technologies bring value…comprehensive solutions like Giulia showed PLEX and NES and clearly, we are the diagnostic specialists.

Diasorin strategy and Molecular diagnostics is aligned with the market evolving landscape leading the way to enabling diagnostic stewardship. I don't know how many of you are hockey fans, but there was a hockey player, Wayne Gretzky, and he was asked once why are you so good and he said because I skate to where the puck is going to be not where it is. That is Diasorin Molecular. We are going where others haven't gone yet, and we have come with a solution…a set of solutions that solves a problem not just today but into the future.

With that that closes our session on molecular. I now also have the great responsibility of our licensed technology business. As Carlo mentioned licensed technology is done through partners. We have

roughly 50 partners with products about 8 to 10 of them are our largest partners, but we are working with companies who are in start-up mode. There are others that are in mid-range that continue to develop products for the future. It is mainly a B2B business and we are seeing that the headwinds and life science in the US are slowing.

So let me quickly give you the left side of this chart, is the revenue split by segment. We serve 3 segments, Diagnostics, Life Science and Pharma, and I will go into each of these in detail. The size of the business is roughly €156 million. In diagnostics, as Carlo also mentioned, we're serving specialty partners in transplant, autoimmune, and infectious disease. In life science, its basic research, its applied research, but it's also pharma discovery, which I'll cover in the next slide. 80% of those revenues are recurring. The rest is instrumentation and services, but 80% is recurring.

So, on the right…and the right side of this slide is the business model. We, as under the Luminex brand, sell consumables to our partners. Those partners take our consumables, integrate them into their custom products. Those custom products are then sold as kits to end users, and they give us a royalty based on those kit sales. So, we have a sale of a consumable at bulk. We have the royalties coming back, and of course, we have instrument sales. So that's the market. There is direct to pharma, and I'll explain that in a minute, where we sell direct to a specific category.

So, let's go to diagnostics. As I said, the 3 areas are transplant, autoimmune, and some very specific LDT partners. Their specialty applications, this segment is very stable and very profitable. The TAM is roughly 1.4 billion at 6% CAGR. We have 40% penetration of Luminex xMAP technology in those sectors. Transplant over 90%, autoimmune roughly 40%, and then testing services, the LDTs is roughly 10%. On the right side, you see the instrumentation, and we also have 2 models.

They can acquire an instrument for us, or they can acquire a module, the reader, that they put inside of their system. It's kind of like an xMAP inside, Intel inside kind of concept. Our major partners in diagnostics, One Lambda, Bio-Rad, and Wearfin [ph], and their end users are commercial labs, hospitals, and transplant centres.

Now we go to life science research. Here they're ready…they're building ready-made multi-analyte panels for pharma, for discovery, and academic research. There are more than 1,300 products built off of the xMAP technology. Our penetration in that space is 30%. On the right, you see the key kinds of products that they make, biomarker panels, gene expression, quantitative proteomics, again, instrumentation. Also on the right, that's a ThermoFisher Integrated where they've taken an iFlex and integrated their automation.

At bottom, you see our major partners, ThermoFisher, Bio-Techne, Millipore, and Bio-Rad, and you see the end users, academia, pharma, discovery, and applied research. So, I'm now going to talk about pharma, and you may ask, well, Angelo, if you're selling…if your partners are selling kits to pharma and discovery, why should you, Luminex, Diasorin, sell to pharma? Something happens. When they're doing their broad panels, High-PLEX, they're trying to find their biomarker.

When they decide the biomarker for their drug or their vaccine, that starts to become proprietary. When it becomes proprietary, you don't want other pharma companies to know what you're doing, and if you go to one of the large…one of our large partners, it could be that they start to make the panel for you, the kit for you, and now all of a sudden, your secret gets out. So, what we do in the case of partners or pharma that's going from Phase 2 to Phase 3 trials, some of them make their own assays in-house.

We then sell our microspheres, our xMAP technology, directly to the pharma in that case, and they in their lab build their own proprietary assays to control that, which makes sense, right? So, that's how we're involved in drug discovery and vaccines. We're involved with a partner with Merck on Project Advance, which is a very intriguing program where this is a fully automated Phase 3 clinical study going to be running 24 by 7 samples, patient samples, hundreds of thousands of samples, and our technology was chosen with one of our partners to be implemented in that solution, and it just shows the breadth of this. Now, this is all going to be driven AI.

The entire thing is robotics and AI, and so when you think about the xMAP technology, it's not for a few days. We see a deep and strong future as well. So, bringing it all together, we have a resilient partner-driven business delivering recurring revenues and long-term growth opportunities.

We've got a strong revenue base, diversified business models. We're looking at different…multiple end markets, scalable platform, large installed base of Luminex, active market fundamentals across the segments, solid TAMs, and lastly, strong ecosystems that our partners had that we get embedded to. It's truly a remarkable opportunity, and I'm very blessed to have responsibility for this business and to have these relationships with great partners.

With that, I'm going to turn it over to my good friend, Alberto Donati, the tallest person in the world.

ALBERTO DONATI: Grazie, Angelo. I was hoping for you to say the second smartest person that you know. I just got the tallest person that you know. It's okay.

Good afternoon and good morning, everyone, again and thank you for joining us today here in person or if you are connected to our Capital

Market Day. It is truly a pleasure and honor for me to be presenting to you today, not only because it is my first Capital Market Day as the CFO, but most importantly, because I have the opportunity to translate all the strategy that you just saw into a financial outcome. Now, before getting into the numbers, allow me to spend just a couple of minutes through our ESG.

Now, our ESG plan is based on clear priorities and measurable outcomes across environmental, social, and of course, governance. On environmental, our objective is very clear and concrete and measurable, it's to improve our group's energy efficiency. What is the target? The target is to reduce 600 tonnes of CO2 across all our industrial sites globally, so molecular and LTG, as well as immuno.

And from an environmental standpoint, we also have other initiatives. Some of them, you will see them on our website, for example, alongside with engaging our employees on environmental volunteering activities. From a social standpoint, we are committed both internally and externally.

From internal standpoint, we want to strengthen diversity and inclusion, and we have a clear target of having 100% of our employees being trained on diversity and inclusion. We also want to enhance our employees' well-being, with a clear target of over 80% of our group employees covered by assistance programs.

On the other side, from a social commitment standpoint, we also want to reinforce our external commitment, because this is deeply rooted into Diasorin's scientific identity.

This is through our Diasorin Foundation, the Fondazione Diasorin. Many of you know the Mad for Science, which is a merit-based competition, and Diasorin is fundamentally creating and upgrading scientific laboratories for high schools.

This is a merit-based competition among Italian high schools. And we fund the scientific laboratories of those schools that demonstrate the best scientific project. And this initiative also allows us to finance and to support the STEM education, as well as to support the future generation of scientists.

You heard it before. We also have a commitment in terms of supporting women's health, adult immunity, with a clear target of developing and validating before 2030 over 20 specialty assays. Of course, we also have…we want to reinforce the importance of the governance in ESG, and we want to further embed ESG into our governance model by including, linking the executive remuneration on the clear targets of our ESG program and of course, this is a key in order to ensure accountability and alignment across the entire organization.

So, now let's get into some numbers. My colleagues have perfectly outlined the business foundations that are the foundation of our plan, as well as the opportunities ahead. I have now the opportunity to translate them into financials, starting from the top line, the profitability, the generation of the free cash flow, as well as the capital allocation. So, as always, all of my remarks and all of the numbers that you will see are at constant exchange rate in order to ensure transparency and comparability.

So let me start with the top line, where our performance trajectory is both ambitious and achievable. For 2026, we are reiterating our guidance of revenue growth between 5% to 6%. Looking beyond 2026, we have a clear target of revenue growth between 6% to 8% of compounded annual growth rate of CAGR. And this is well above market rate. And I have to say that in the context of our market environment, this represent a strong and compelling objective that is fundamentally supported by the strategy and…the well-defined

strategy that has been discussed before, as well as our commitment on execution across the entire organization.

When we look at the different mix, the portfolio and the technology mix of this growth, we see a differentiated profile. So allow me to start from the bottom on our immunodiagnostic business that continues to be a core part of our group. Immunodiagnostics is expected to grow mid-single-digit in 2026, as well as throughout the plan in 2030. And this is supported by the strength of our specialties, as well as the growth and the solidity and the resilience of our installed base.

It is important to note that while we are confirming a mid-single-digit increase between 2026 and 2030, growth may not be linear. Why? Because we may have the potential competition in the later tuberculosis market that may cause some fluctuation year-on-year, but at the same time, we're still confident and comfortable with the mid-single digit increase target.

Moving into molecular, of course, we see the molecular as a different growth trajectory. In 2026, we have a low double-digit increase while we are expecting looking beyond 2026 into 2030 to have an increase into the high teens. And this is, of course, supported by the success of the LIAISON PLEX, as well as the commercialization of the LIAISON NES, where we have set clear target for us. Starting from the LIAISON NES, the clear target is over $150 million in the US market, because this is clearly an opportunity that we see for the US market. So that's where we're giving the target.

For multiplexing, which has been launched not only in the US, we expect this to be over €180 million throughout 2030. It is important to know that these 2 targets are expected to support the lower end of our guidance being 6%, while any upside that we may get with those with the LIAISON NES and the multiplexing overall can support the growth up to the higher end of our guidance being 8%.

Last but not least, LTG, where we are expecting a growth low to mid-single-digit both in 2026 and throughout the plan to 2030, broadly in line with the market dynamics. So this profile is showing a clear trend of shifting and focusing on the growth of the molecular diagnostic, while also maintaining the stability and the profitability of our immunoassay and LTG franchises.

Now, geographies. Geographies are equally important to the narrative and the story of our guidance. Starting from North America, again from the bottom, we see that we are guiding for 2026, a high-single-digit increase. As we know, North America has been affected in the molecular diagnostic business by an especially low flu season, which in 2026, which is compared to an especially high flu season in 2025.

While looking beyond 2026 for North America, we are projecting low double-digit increase. Of course, as I mentioned before, supported by the launch of the LIAISON NES, as well as, the continuous success of the LIAISON PLEX. At the same time, we also have to mention the importance of the hospital strategy, which has been an important key driver of the last 4 years, and it will continue to be a key contributor in the coming 3 or 4 years.

Moving into Europe for 2026, we are expecting a low to mid-single-digit increase, as well as, low to mid-single-digit increase throughout 2030. We mentioned it in the past; European countries have experienced an especially high-volume testing in the post-pandemic phase. While we are now in a normalization phase where the volume testing is going back to the pre-pandemic levels. At the same time, we are confirming a leadership position in many of the specialty testing where we are growing at or above market rates.

Regarding the rest of the world, we see a softer performance in 2026, and this is fundamentally due to 2 factors, the continuous negative

performance of China because of the VBP that has been mentioned in the past, as well as the conflict in the Middle East that has affected not only the Q1, but we expect to be affecting 2026. This has been offset by the growth of the other data direct markets where we are present, namely being Australia, India, Mexico, and Brazil.

Looking beyond 2026, throughout 2030, we expect a recovery into the mid to high-single-digit increase, thanks to a combination of growth into the direct countries that I just mentioned as well as export.

Now, all of the mix that I just described, of course, will change a little bit…all of the growth that I just described will change the mix of our revenues. Starting from 2026, we see molecular diagnostic being 17% of our revenues. They will almost double by 2030 becoming a third of our total revenues. And this is consistent with the strategy that we had set leveraging the Luminex acquisition. At the same time, immunodiagnostics 70% to 60% and LTG from 13% to 10%.

We've mentioned it in the past. Molecular diagnostic is less profitable inherently a less profitable technology compared to immunodiagnostic and LTG. And that's why we are expecting to have a margin mix headwind. Of course, we are not simply accepting this headwind. We are actively managing it through industrial efficiencies and a strict and disciplined cost management. And that's why the commitment to margin expansion that I will discuss in the next slide is so significant and so important.

Mentioning the geographies, you will see also that North America is moving from roughly 50% to being 60% of our total revenues. In this case, it is important to note that as a majority of the products that are commercialized in the US are manufactured in the US, specifically 100% of the molecular products are manufactured across all of the sites that are sitting in North America. This is helping us when we see

what's happening in the macroeconomic environment, especially with tariffs.

So let's look into our target in terms of profitability. For 2026, we are confirming the guidance of 32% to 33% adjusted EBITDA margin. And let me remind you that this guidance does not take into consideration the potentially negative impact of a prolonged military conflict in the Middle East.

What do I mean by that? We've mentioned in the past that although we don't have full visibility of what could be the full impact in the future, we have an estimation that this could cause on an annualized base, could cost between €8 million to €10 million between the cost increase in the distribution as well as the material cost, namely, for example, plastics being one of the elements or one of the materials of our cartridges and could be affected by the conflict indirectly through the increasing prices because of the conflict in the Middle East.

Now, what is our commitment? Our commitment is to increase margin by 200 basis points, which is leading us to have an adjusted EBITDA margin of 34% to 35% in 2030. Now, this is, considering the macroeconomic environment, this is a very important milestone and how can we achieve this? Well, fundamentally with 3 levers. First, it's a very disciplined cost management, industrial efficiencies, and operating leverage. So, from an industrial efficiency standpoint, we are optimizing our footprint, we are as well as optimizing our supply chain and a disciplined cost management across the entire organization. We are also increasingly leveraging digital tools, specifically AI agents, for example, in order to optimize our processes, increase automation. And this is a model that is embedded into…and this is an approach that is embedded in our operating model, and so we expect this to deliver benefits over time.

Of course, expansion of margins translate into cash flow generation. For 2020, for the period of 4 years, 2027 to 2030, we expect to generate around €1 billion of free of free cash flow. And this is, of course, after considering all of the investment in CAPEX in order to support the organic growth of the company, which I will discuss next in the capital allocation.

So allow me to move into the capital allocation where we have a clear framework focused on long-term value creation. Our Chairman, Dr. Denegri, mentioned it earlier at the beginning of this session. Our first priority is organic growth.

Our first priority is to continue investing in the business to support the long-term growth. What did we do in the past 4 years? We've invested around €500 million in CAPEX and organic growth. And this is around 40% of that cash generation. What are we planning for the next 4 years? We are planning for the investment to be broadly stable in absolute terms with a ratio on operating cash flow decreasing from 40% to 35%, simply as a function of the increase of the cash that gets generated.

Second, we are committed to continue delivering an attractive shareholder return, consistent with what we've done in the past, progressive dividend increases. Up to €250 million is what we have distributed in the past 4 years, around 20% of the operating cash flow. Our commitment is to continue with that policy, and that is another 20% allocated to dividends.

We will also remain highly selective with the remaining financial availability. Our chairman mentioned it earlier. We will only be focusing on targeted M&A, bolt-on acquisitions that are aligned with our strategic roadmap, while maintaining the flexibility of potentially share buyback if the flexibility allows…the balance sheet flexibility allows it, and the shareholders decide to do so.

I believe that this concludes the part of the financial outcomes. Before I conclude, let me just remind the 3 key financial takeaways. First, a strong growth, 6% to 8% throughout 2030, well above market rate, thanks to a clear and well-defined strategic roadmap, as well as a solid portfolio of specialties. EBITDA, adjusted EBITDA margin expansion of 200 basis points, leading us to a target of 34% to 35% in 2030 and around €1 billion of free cash flow generated to be used with the capital allocation mentioned also before. Thank you.

CARLO ROSA: So, let me just conclude the day. I'm not going to repeat the takeaways, I think. I just want to do…I want to say thanks to all the people that have been working to deliver the results and, by the same token, to preparing this plan. It took it took a long time, long nights and long flights from you guys that came in from the US. So, thank you very much to my colleagues.

And I would open up now the Q&A session. I think we start from the room, and then we take the one from the phone. Yes. Please, Aisyah. You need a microphone?

Q&A

AISYAH NOOR: Can you hear me? Can you hear me?

COMPANY REPRESENTATIVE: No.

CARLO ROSA: No, not yet.

COMPANY REPRESENTATIVE: Now better?

CARLO ROSA: Yes, thank you.

AISYAH NOOR: That's great. Hi, it's Aisyah Noor from Morgan Stanley. Thank you for taking my question. I have actually 3, one for each Carlo, Alberto, and maybe Chen, if willing. The first one is on the mid-term growth outlook for immuno of mid-single digit growth. So, in the past 3 years, your immuno diagnostics business grew 8%, and in the past 10 years, it also grew 8%. So, I'm a bit curious as to why you've taken a more modest approach on your mid-term growth outlook. And this is despite, you know, the growth drivers you've highlighted in GI, in, you know, MeMed, and autoimmunity. Is this a reflection of the market volumes a little bit slower growing, or is it pricing pressure from reimbursement or competition or is this a more conservative approach from the Diasorin management team to guiding for the for the future?

Second question also on the immuno business, on the autoimmunity market opportunity. You've called out 750 million market opportunity there. My understanding is the testing options is quite entrenched, i.e., you know, the clear market leaders like Thermo and Werfen are there. So, what is your strategy to winning share from these very established players? Yeah, so that's my second question.

And then the third one is just again on capital allocation. Would it be fair to assume now, given where your share price is, is that it's more opportunistic to do buybacks more regularly near term, rather than it being a, you know, taking a back seat? Or do you still think, you know, other areas of capital allocation like, for example, M&A? And if so, you know, what would look interesting in your view?

CARLO ROSA: Okay, I'll take the questions. So, let's start from immuno, right? Yes, you're right, we've been growing a lot in the last few years. But as you said, I believe that there are couple of things that changed, right? One is that volume in the last 4 years, especially in the European market, it really helped a lot. And you saw what happened. I think we've been discussed it during the quarterly results. We went from 6%, 7% volume increase to 1.8%, right, which is I think the reality of today.

And actually, goes back to what it was in 2019. So, the long tail of COVID is, I think, done, right, so we need to take that into consideration.

Second thing is that we foresee competition coming in TB, as you discussed. I believe that that typically put pressure on pricing. So, the model takes into account that in the 2027, 2028, there is going to be trough because of the competition on price. That's the assumption, and we have no idea about the quality, the level, the commitment that Roche will have on the assay. So, we will comment later what is going to happen. But knowing Roche, that is a fairly formidable competitor, I believe that they're going to put an effort, and I believe that, as it always happen, price is going to pay is going to be a point of contention.

The third element is that China is gone, right? And now you go back 10 years, and so it means that the good old days when China was 30% of the growth, now China is….has been actually 30% of the decline, right. And we foresee stability in this model of the Chinese market that is not declining, but it's shifting from a me-too assay country to a specialty country.

So you expect a margin improvement, but it's not going to be contributing to growth. And this is why I believe that for a €800 million franchise, taking all these into consideration, it makes sense to look at mid-single digit, okay? Were growth, you're going to keep seeing high single-digit growth in the US, but stabilization in the European market. When it comes to autoimmune, I think let me just summarize the strategy very simply. Yes, you're right, today they are in tranche competitors. But I believe that the market is changing and it is funny that a specialist is telling this to you. But I believe that TLA suppliers, the 4 major companies, are going to try to take away from the specialty lab whatever they can. And customers will be with them

because they cannot afford any longer, right, that these specialty labs where you have the education.

And if you think about it, our own specialties migrated away from the specialty lab into the core lab years ago. And we were able to actually keep that business, because we are unique, but also because we connected to everybody. As Chen said, 25% of our revenues, of our system placement today sits with Roche, Siemens, and Abbott, or a Beckman platform, right? It's going to happen. It's going to happen to autoimmunity.

And the companies you are talking about don't have today a strategy for connectivity, right? What does it need to be a credible autoimmune supplier? You need a menu. And 20 is the entry point, 30 as is what you need, right? But the strategy in this case is follow, follow the big guys, help customers to move into the core lab system with autoimmunity. And that is going to be our plan. The last question was?

AISYAH NOOR: Capital allocation.

CARLO ROSA: Capital allocation. Look, typically Diasorin has not done a lot of share buyback, right? It has been a recent event because of many consideration that the shareholders we made with Mr. Denegri. We are all convinced that we want to actually buy technology. We will invest in the company. We want to be selective in bolt-on acquisition. We invested…in the last 10 years, we invested over 2.2 billion in M&A. But I think what this says is that if the market doesn't offer these opportunities, right? And we did as a shareholder that it makes sense. We are going to deploy capital creating value through also the mean of the share buyback, okay?

AISYAH NOOR: Thank you very much.

CHARLES PITMAN-KING: Charles Pitman-King from Barclays. 2 questions for me. Firstly, just to Alberto. Coming to your EBITDA margin bridge, just thinking about the kind of gross margin headwind, I calculate it's around 50 to 100 bps that you have to try and offset with these cost savings. But in terms of then delivering on the 200-bps expansion. Can you maybe break down a little bit where you see the opportunity for gross margin and SG&A and R&D on that 2030 target?

And then a second one for Carlo. Noting the incremental headwind from China, but the raised rest of the world target. Just wondering, if you can talk about the key countries, regions you think are best placed to support that mid-high single-digit growth?

ALBERTO DONATI: Okay. So let me start. Thank you for the question on the EBITDA margin expansion. And let's start from the top, from the gross margin, and then I'll move into OPEX. So starting from the gross margin, as you said, we have a mixed headwind. What are we doing about it? We have programs for product cost reduction in order to offset it, and we have industrial efficiencies as well as industrial footprint optimization. This is what is going to help us to offset the mixed headwind.

On the other side, what do we have in terms of leveraging? The fact that our OPEX is not going to grow at the same rate of our revenues. You may remember that we have shared with the market that we made an investment in the neighborhood of $10 million for the launch of the NES, and this is an operating expense that has started this year, and that is going to fuel the commercialization of the NES throughout the years of the plan. So fundamentally, we've been starting to invest this year, and so we don't need to grow OPEX at the same speed of the revenues. So the gross margin, the OPEX, and third element is purely the operating leverage coming from the top line growing with the gross margin, not…unfortunately, not expanding, but also remaining broadly stable, and OPEX growing less than revenues.

CARLO ROSA: Just one more comment about this. If you notice, we shut down 2 manufacturing plants recently, one in Germany, one in China. And we are consolidating Immuno, which is the high-volume technology, into 2 plants, and the US and Italy, almost, almost of same size. And that is where we invested heavily in automation, and so we expect, because of this consolidation, that now you are going to be reaping the benefits of this move. The other thing is that, as everybody knows, Italy is a wonderful place to manufacture because attrition rate is very low, you get talented people, and cost of labor is very reasonable compared to other countries. So that mix, especially in Immuno, is going to really help you to work on your…absorb the negative effect of the gross margin dilution due to the Molecular.

Your second question was about ex-China, where else do…and ex-US and Europe, where else, right?

CHARLES PITMAN-KING: So you have a mid-to-high digit growth target for the rest of the world?

CARLO ROSA: We have…let me split the world in 2…at least in my, in my mind, in 2. We have countries where we are direct, right? Australia, India, and then we have Mexico and Brazil, okay? Those countries continue to grow double-digit, have been contributing double-digit to the growth of the company, and will continue to grow double-digit, right? Opportunities. I believe that there are…there is…there are 2 regions where today we are completely under-penetrated. Well, let me start from the one where we don't sell a cent, Japan, right? Today we don't sell a single dollar in the Japanese market, which is an insult to common sense. And so, what we expect is that we need to invest and look into a Japanese strategy, especially because bioMérieux has showed very well that in the molecular space, both decentralization and multiplexing of quality is an opportunity, okay? So that's an area [ph] of interest.

Second one is Saudi. Saudi until yesterday, literally, was an area where we were planning to move some local manufacturing and become one of the few, if not only diagnostic company, expanded in that market because it's a wonderful, wonderful market. We had to stop, as you can imagine, but we will restart, right? So it's actually the Middle East is an opportunity where you can really invest. I am, by the same token, a little bit negative about India for 2 reasons. So we have a very small, less than $10 million business in India, growing double-digit. Can that become a true opportunity of $50 million, $100 million? I don't think so, for 2 reasons. First one is that pricing is unaffordable. Second one is that they will open to the Chinese. Today, they are not open to Chinese products. Tomorrow they will, because of the recent geopolitical situation and the Chinese will…are going to get to India because they can afford the low price, and I think outcompete us in the geography.

CHARLES PITMAN-KING: Thank you.

CARLO ROSA: Please. It will come. Ladies first.

ANNA RACTLIFFE: Hi, Anna Ractliffe with Bank of America. Thank you for the presentations. I wanted to dig in a bit on the molecular growth. It seems like that's a really important part of reaching the midterm target, expecting to grow high teens when historically maybe it hasn't delivered at that level. It seems dependent on the NES launch, the GI panel, just what's giving you confidence that you can hit those levels if the flu season remains weak?

And then on the 150 million target for NES, how much of that is just with the existing panel and how much of that is reliant on incremental panel launches, for example in women's health that were discussed in the presentations?

And if I can maybe tack one more on, I know it's early days but what initial feedback are you getting on the product? Are your placements more maybe competitive conversions or white space? Just any thoughts that would be appreciated.

CARLO ROSA: Okay, I am going to leave the last question to the most honest lady you have in here. That is Giulia, right? So molecular, the problem unfortunately is that in 2025-2026, all our placements for PLEX have been on respiratory. So we are going to double whammy, which is very, very low respiratory season is not showing the growth. And since we are not giving placement number or we give an indication of number of systems placed, right? Then everybody believes that the PLEX is not working, right. What I am telling is it is working, but it is suffering, unfortunately, the respiratory system.

I'm very confident about the PLEX for what Giulia said, but because the market is changing. And either you cope with the fact that there is no more money, and in the US, since you are American, reimbursement is becoming a big thing, right? And these insurance companies don't reimburse any longer the high multiplexing panels. I think Giulia touched on Alabama, which is a very interesting concept, because Blue Cross Blue Shield, right? They stopped reimbursing the 15 PLEX. Stopped, right, because they saw it as unneeded, and actually it was too expensive, pushing everybody to do a 4 PLEX. And guess what, I received the first picture, I received one week after the launch of NES, where 6 systems in Alabama, right, because now the market is going to move there, right?

When it comes to NES, $150 million, yes, there is no women health. It's all respiratory, right, because women health is going to be launched in 2029, right, effectively, and it's going to have a very good effect because it's non-seasonal, right? Whereas today, the respiratory plan is seasonal, but it's not going to affect dramatically these numbers, right? So it is an opportunity, right? It is an opportunity that can help us out

to go from the 6% to 8%, which is what I believe Alberto was hinting. Giulia, feedback.

GIULIA AMICARELLI: Yes, this has been a journey since the launch. We trained all our distributors. We basically launched with them just in April. The reaction from the distributors who do really know this field has been extremely positive. And with them, we closed already several contracts in just a few weeks. So I should say that the feedback was positive. Something that resonated very much behind what Carlo just said is, for example, displacing time…because of the time to result and really the easy workflow that I explained to you seems to be actually resonating with the field. So I'm pretty happy about it. I was with the McKesson National Commercial Meeting last week and it was positive. Thank you.

CARLO ROSA: Just one thing to add to the NES. The…it's not that there's a F.A.T.E system, the Roche system and [indiscernible] system or the Abbott system. They had enough, but they're old. They've been launched 10 years ago. And so, the CFH system takes 38 minutes to a result. The Abbott system, there are 40,000 systems placed in the US. They have the triplex and you naturally need to run 3 different assays to get the respiratory panel.

So, I believe that what the opportunity offered by the NES today, which you saw there, is that it's been designed in 2026 for the current market. It's not a 2015 system designed for the hospital market. This is what you taught me, right? They were all designed for the hospital market and now they try to fit it into the POL. They got a kick during COVID. There was nothing else, right? But now that customers have an opportunity, this system is way more friendly.

NATALIA WEBSTER: Okay. Hi, Natalia Webster, thanks for taking my questions.

CARLO ROSA: I said ladies first, okay.

NATALIA WEBSTER: I have 3, please. The first is just a follow-up on your margins and R&D. You talked to sort of cost efficiencies and operating leverage going forwards, but what do you see as a sustainable level of R&D to continue your innovation in the specialty space?

And then the second question is on immuno. You talked to the 20 new assays in immuno by 2030. Are you able to talk more about the timelines you expect from these launches and what sort of contribution you expect from these new launches versus existing specialty tests such as the TB and MeMed, for example?

And then my third question is a follow-up on the PLEX. You're guiding to more than 180 million of sales by 2030. Believe you were previously targeting around 200 million by 2028. So just curious to hear on the change of outlook here and what's made you a bit more conservative. Thank you.

CARLO ROSA: You first?

COMPANY REPRESENTATIVE: Okay. Natalia, so R&D. In the past, as you know, we've been having extremely high R&D costs linked to the fact that we had 2 platforms under development to be launched in the past. Angelo mentioned it before. 11 FDA clearance in the last 3 years. Behind that, there is clearly an extraordinary R&D effort. We were in the double-digit…as a ratio to revenues for R&D, we were in the double-digit.

So now we see, what we consider simply the normalization, the cost of the clinical studies that is going to decrease, the cost of the consumption of all the materials that are necessary for the development is going to decrease. So we're going to go from clearly double-digit into the single-digit. This is not to…without giving specific target, we're still allocating a large portion of our investments, around half of

them, into the R&D. But at the same time, we are going, as I said, into a normalization phase where that amount is going to be more than sufficient to support the growth and the development of the new panels. Some of them have been already mentioned by the team, being the ME, for example, in PLEX, the STI, the women health in NES. I believe that was, okay, the first question.

CARLO ROSA: Second question on contribution of the news panels, not now, right? I believe that we're going to make this plan not because of autoimmune, because autoimmune is coming in 2028. So the contribution is not going to be there. Autoimmunity is an investment that we make for the next cycle, okay? But we're going to be more specific when we get closer to the launch of these products. 180 million versus 200, if you do the math between 6% to 8%, right? So what does it mean to go to minimum 6 to maximum 8? Then you get a span, right, where at the end of the story, there is no difference between 180 and 200, right?

The difference is why does it take longer to get there? And it has to do with the fact that if there is one thing that we have learned in the US, right, is that it takes a hell of a lot of time to place a LIAISON PLEX and do all the connectivity and the software changes to implement in the hospital system, to implement the mini panel. Sorry, the mini panel meaning all the different panels that the hospitals is doing. And actually, that is…was really surprising to us, right?

Our assumption was that between the time that you sign in a customer and you are up and running is 3, 4 months. And now we see that between the time you sign the account and then they are up and running is 6, 9, 12 months, especially if it is a hospital system, right? We have the example of Yale Hospital System, right, Angelo? How long did it take? 15 months.

ALBERTO DONATI: No, 2.

CARLO ROSA: And how many hospitals? 6? Right. So now you're talking about an entire hospital system converted, right to our platforms with the IT having to take all these mini panels that they design, implement it in their IT system, right. And that came from the live experience that now we have in implementing the strategy. And this is why we see it coming, but it takes longer.

NATALIA WEBSTER: Okay, thank you.

CARLO ROSA: Please.

JAN KOCH: Yes, thank you. Jan Koch, Deutsche Bank. I actually have 3 questions and I would like to start with your midterm targets. Your new margin target of 34% to 35% by 2030 is actually below the previous midterm target. Could you please explain that?

And then secondly, coming back to Aisyah's questions, those targets appear less aggressive than maybe in the past. So, has your guidance philosophy changed?

Then secondly, coming back to multiplex and the 180 million target by 2030, could we get the assumed split between automated and non-automated? And you won't like the question, but could we get an assumed installed base by 2030, which is essentially backing your sales guidance. And could you also explain how you count?

CARLO ROSA: I just turned 60, and I can barely remember my name. So let's go one-by-one.

JAN KOCH: Okay. Sounds good.

CARLO ROSA: Start with the first question again, please.

JAN KOCH: Yes. So your margin guidance, 34% to 35%, is below the previous margin guidance. Why is that?

ALBERTO DONATI: Thank you for the question. There are fundamentally 4 reasons. 3 of them are due to the market environment. One of them is by choice and design. The 3 of them are China, tariffs, and NIH funding. And I will explain and expand why. The fourth one is NES investment. China, the VBP was fundamentally a price reduction story. When we gave the prior guidance there was not…the VBP had not been implemented yet, and so we didn't have that embedded in our previous guidance.

Second one, tariffs. I don't need to explain anything further than that.

Third one, NIH. Why do I mention that? Because in our previous plan, we have assumptions of growth in the life science market for LTG that did…simply did not realize because of the reduction in investment that the US administration has decided for the…during the last 2 years. So that has been, in a way, a margin headwind that caused a reduction of our EBITDA.

Macroeconomic environment issue problems. On the other side, we also decided to make an investment and between 50 to 100 basis points is simply given the fact that we wanted to ensure the success of the NES launch.

JAN KOCH: Great. So could you confirm that your guidance does not include a larger buffer than in the past?

ALBERTO DONATI: A large part [indiscernible].

JAN KOCH: A buffer. Like protection in terms of something is not working like you're planning.

ALBERTO DONATI: So we believe that the guidance that we give is ambitious and achievable, as I said before. It does take into consideration the 4 things that I just mentioned, and as I mentioned before, what it does not take into consideration is an extraordinary inflationary impact should conflict continue and see increasing prices that is more than what we have already embedded in our model.

JAN KOCH: Got it. And then secondly, on multiplex, could we get an update on the assumed split between automated and non-automated revenue by 2030 and also in terms of the installed basis that you are assuming?

CARLO ROSA: Listen, non-automated is going to be less than 10%.

COMPANY REPRESENTATIVE: Residual.

JAN KOCH: Excuse me?

COMPANY REPRESENTATIVE: Residual.

CARLO ROSA: Residual. Yes, it's going to be very small. Is it going to make a difference in this plan? No. The problem, as you know of this very old technology is that every day you wake up and you want to kill it, then he does a calculation on margin contribution and you don't kill it. Never, right? So but it's going to be really negligible at the end of this plan. The other question was?

JAN KOCH: Was, how you count the placement? I think you mentioned in one of the recent conference calls that you placed a thousand systems already, but how do you count them given that you have 6 blades in the system? Is it like one instrument is 6 systems?

CARLO ROSA: It's everybody else. Number of blades. Sorry, we call it blade. Number of thermal chambers that you put into customer hands.

JAN KOCH: Okay, got it, thanks. And then the final question on China. You have been quite vocal about the challenging environment and then have recently decided to close one of your facilities. But what is holding you there in that region or why are you not exiting that market? Is it the TB opportunity?

CARLO ROSA: We are not. It's very difficult. Let me just give you. We are there in a joint venture with the Chinese government since 20 years. It's very difficult to leave China 1.4 billion people, aging population, right, forever. And I believe that when you're in a joint venture with the government, you can leave the government, but you better make sure that you leave also the keys of the door. You never go back. Right, and I think that they understood clearly that manufacturing today in China is not adding value. So they have no objection to shut down the plant. And they were also very clear that from a financial situation, a European company locally may decide to say, I'm going to pull the plug, because I'm not making money, but they were also very, very clear to the concept that, but you're going to be missing the next cycle. And the question is, what is going to be the next cycle? Nobody knows, but it's a billion people that need healthcare.

So, long story short, we were very honest in this plan, we said, fundamentally, we are not going to grow. We're going to change the mix. Latent TB, our IGRA assay is going to be approved by July. So, we're going to have that one. Calprotectin is going to be approved next year, and we're going to go from a me-too product strategy to a more specialty strategy with better margins. And then we wait and see. I think everybody is going to be waiting and seeing what the heck is going to happen, right?

JAN KOCH: Thank you.

COMPANY REPRESENTATIVE: Please.

BRUNO PERMUTTI: Yes, Bruno Permutti from Intesa Sanpaolo. A question related to the phasing of the high-teens molecular diagnostic growth. So, how should we model, if you can help us in understanding, how should we model between 2027 and 2030 the high-teens? Can we assume a single-digit in 2027 and then an acceleration? So, if you can give us some hints on this.

And on the legacy business of the molecular diagnostic, so the MDx, if you can give us an idea of what is the assumption in…for growth in your target.

And a second question, if I may. It is related to, okay, the immunodiagnostic business, so the MeMed. You talked about submission for unbundling and for reimbursement requests. Do you have any idea of what could be the timing for obtaining that or, in your guidance, what you assume for this for these test sales?

And very last one related to TB test. Do you believe that you have a competitive advantage in terms of automation of the pre-analytical phase compared to Roche? I mean, in your assumptions, you have only a price competition, or you believe that there could still be some differentiation between your test and that of Roche?

CARLO ROSA: I'll take the last one, so I remember. So, you remember exactly. Okay. TB, the story is very simple. I mean, we sat, as everybody else, on the 12th and listened to what Roche was saying, right? Was CMD, 3 slides out of out of 150, I believe, and they've been talking about their product. They didn't say much. They said we're going to launch it in 2026, they talked about Europe, not the US, they said we're going to have 3 tubes, and the supplier of the tube is a Korean company. Okay, this is as much as we know about this. Okay? They clearly said that we have 48,000 system placed worldwide, which is a fact. Okay? So, we tried to say why we believe today we are better. We believe we are better because we have the gold standard, because we are CD4 CD8,

right? Whereas, it looks like they have a CD4 only assay. It is because we have been working thoroughly with the FDA with QIAGEN to get all the possible population, patient population validated on our assay. I don't know what they will come up with, right?

In terms of analytical and pre-analytical, they say they're going to come out in 2029 with their system, right? Whereas, 2028, 2029, I don't remember the date. But 2029. But actually QIAGEN, I believe one day before they did their CMD, QIAGEN said that they're working with Tecan for a 2027 launch of the pre-analytical. So, long story short, it is very early, in my opinion, to talk about competition on TB. We modeled some assumptions on price, right? Stay tuned. We all stay tuned and we see what is going to happen.

Sorry, one more thing. Let me give you one more element to read competition. The number one market for TB, guess what, is the US. In the US, this test is highly concentrated in…as for everything, into LabCorp and Quest, 2 major labs. That's not a secret. We are in LabCorp and Quest together with QIAGEN. We have contracts with LabCorp and Quest, as everybody else in the US, right? So first, we need to understand when Roche is going to show up in the US. They don't know. We don't know. But second, when they show up, I mean, there is a concentration of business in laboratories where we have been there and we contracted that business for a long time. Same consideration is for Europe, because Italy, for example, where we have 100% market share, is a tender business. Tenders last 5 to 7 years. Funny enough, in some of the tenders, we are connected with TB to the Roche system, right? Because we want tenders together. So I think I gave you enough food for thoughts.

BRUNO PERMUTTI: Thank you.

CARLO ROSA: Let me try to kill 2 birds with a stone and answer both of your questions at once. The short answer is pretty consistent incremental growth in absolute terms. So let me break it down, because you asked about the low plexing, fundamentally. But there are 3 elements to the growth, the low plexing, multiplexing and point of care, right? So for point of care, for LIAISON NES, you do have a clear target that we have disclosed.

And in terms of incremental absolute terms, we are going to be pretty consistent. Of course, from a percentage perspective, that generates a variance, but pretty consistent increasing in absolute terms as well as with the multiplexing.

When it comes to the low plexing, we have been describing in the previous calls the growth of 40% of specialties every single quarter consistently for the past year and a half, I believe. That growth, again, in absolute terms is set to continue, but of course, it's not going to be 40% forever. It's going to get diluted simply for the fact that the base…customer base is going to increase. The respiratory one, which is the other component of the low plexing, apart from the specialties, is going to be more stable overall across the duration of the plan. So low plexing between specialties and respiratory, one growing, the other a little bit more stable. LIAISON NES, you have the target of the $150 million incremental and consistent in the incremental revenues generated every year. And same thing with the multiplexing.

BRUNO PERMUTTI: Thank you. The last one was on MeMed, if you have any idea of the timing of the possible answer to the request for reimbursement.

CARLO ROSA: I appreciate the question, but I believe it's better if there is any.

COMPANY REPRESENTATIVE: Yes, 2. 1 about the CMS, the decoupling. Well, it's not easy to get decoupling. Every year there is a committee and they lost last year. So it's going to take one more year at least to know if it's going to be a

go, no-go. As far as talking to the privates, they are already deep in discussion with those privates. I cannot disclose the names because they asked not to, but fundamentally they believe at the end of the year, some of the big guys, there is one big guy that controls about 40% of reimbursements in the US, private ones. They are very much into it. They were all part of the Jupiter design study. And since they saw the genius ones, they are now very motivated to say, you know what, it's a go. So I hope I am answering your question.

BRUNO PERMUTTI: Yes, thank you.

PHILIP OMNOU: Thanks for taking my question. This is Philip Omnou from JP Morgan. 3 questions, please. On the first one, on the margin guidance, how should we be thinking about the phasing of the 200 bps of improvement over the period? Are you able to quantify that bridge or the breakdown of the components which get you to that expansion, so you know when you talked about operating leverage, cost efficiencies and cost management to offset the mixed headwinds.

Second question, just to circle back on TB, and I know Roche didn't speak much about TB there on their diagnostics day? But are you still comfortable with your assumption for the full year for 2026 that it should have a minimal impact or have you sort of adjusted that assumption following that diagnostics day?

And as a follow-up to that, can you outline what your exposure to TB is as a percentage of yourselves just to help us when we're modelling? So is it more like a 3%, 4% of revenue or is it more like a 10%-15% business?

And last question for Alberto please. You mentioned in immuno that growth shouldn't be sort of linear because of the competitive entries. So just to be clear, are you sort of implying that growth should be more

say front-end loaded until you see more competitive entries or just a bit more color there would be helpful. Thank you.

CARLO ROSA: TB. I'll take TB. 2026 is not going to be affected by TB by the launch of a product simply because the time today takes to validate. Assume that for a second that a customer decides to switch which means that they need to do all the evaluation first. It's month, right? So mathematically there cannot be an impact in 2026. This is why I discount anything significant. As we are thinking, we've been discussing with QIAGEN for TB, there was a different story which has to do with impact of immigration and immigration testing in the US with TB. Nothing to do with Roche.

Second question, how much is TB? Can't disclose obviously, but I think some of you said that TB for Diasorin is less than 10%. You meaning not us. Some of them estimated less than 10% and yes, it is less than 10% of the revenues, right? The other question was…

ALBERTO DONATI: So I'll try to take the margins expansion. I'll try to link the first and the last one, because they are deeply correlated. So phasing of the margin expansion linked to the fact that we have price pressure coming from the competition. So as Carlo just mentioned, we are not expecting to have competition affecting us in 2026, but most certainly between 2027 and 2028. And since we're expecting competition to also affect us from a pricing standpoint, when modelling the margin expansion in a time from a phasing perspective, you have to imagine that it's going to…the expansion is going to be a little bit more skewed towards the second part of the plan, simply as a function of having price impact affecting us in 2027 and 2028.

So, I believe that hopefully I answered the first and the third. Regarding the breakdown of the 200 basis points of expansion, what I can say going back to what mentioned before is the fact that you will

have an offset of headwind in the mix being affected by the efficiencies and then the operating leverage being the main driver of the expansion.

CARLO ROSA: No more questions. Okay, is there any question coming from the web that we didn't cover? No. Everything. Okay. Listen, thank you very much for coming. Thank you for your patience and safe trip home. Thank you.

ALBERTO DONATI: Thank you.