THE PROMISE OF MULTI-CANCER EARLY DETECTION

CLINICAL OVERVIEW

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GRAIL, LLC.
Founded in January 2016 to take on one of the world's biggest challenges
Headquartered in Silicon Valley – the hub of life sciences and tech industries
World-class team of leaders, scientists, clinicians, engineers, and other experts
Acquired by Illumina in August 2021 for ~$10B in consideration
Rapidly growing to >1200 employees by end of 2022
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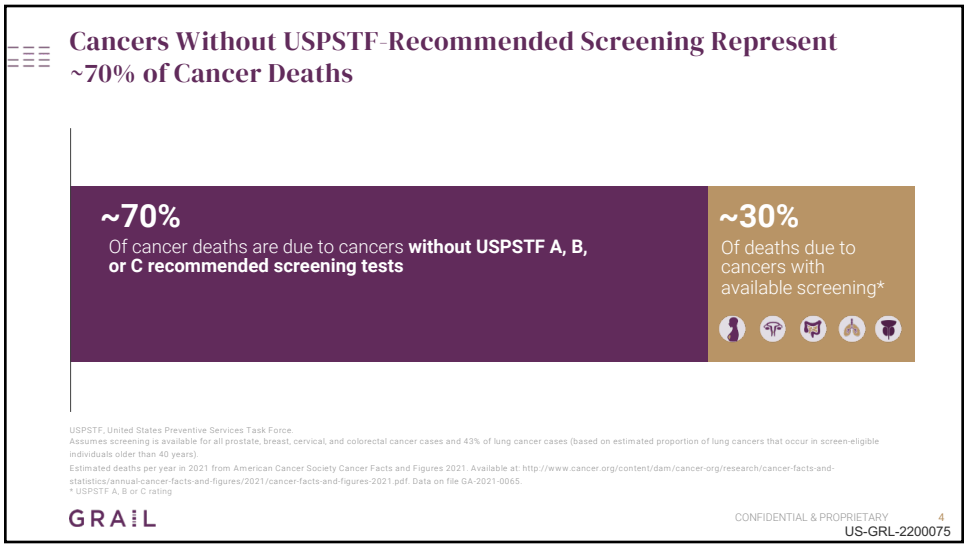
Cancers Without USPSTF-Recommended Screening Represent ~70% of Cancer Deaths
~70%
Of cancer deaths are due to cancers without USPSTF A, B, or C recommended screening tests
~30%
Of deaths due to cancers with available screening*
USPSTF, United States Preventive Services Task Force.
Assumes screening is available for all prostate, breast, cervical, and colorectal cancer cases and 43% of lung cancer cases (based on estimated proportion of lung cancers that occur in screen-eligible individuals older than 40 years).
Estimated deaths per year in 2021 from American Cancer Society Cancer Facts and Figures 2021. Available at: http://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2021/cancer-facts-and-figures-2021.pdf. Data on file GA-2021-0065.
* USPSTF A, B or C rating
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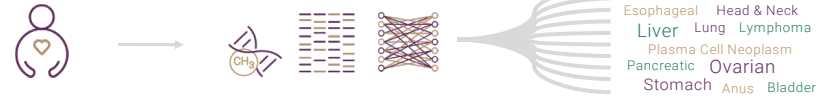
GRAIL Has Developed Galleri®, a Multi-Cancer Early Detection Test



Single blood draw

Detect cancer signal with **targeted methylation sequencing** and **machine-learning** classifiers

If cancer signal is detected, **predict cancer signal origin** to direct diagnostic work-up

Test is **targeted for use as a complement to guideline-recommended screening** (eg, mammography)

Designed to detect **detect a cancer signal common to >50 cancers, including unscreened types,** from a single blood draw

High specificity (~99%) minimizes false positives and unnecessary work-ups

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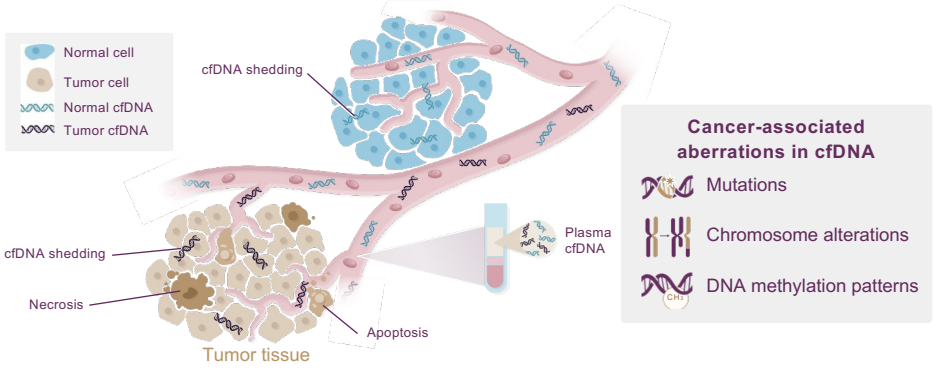
Tumors shed nucleic acids into blood and other body fluids, carrying cancer-specific information[1,2]



cfDNA, cell-free DNA.

1. Corcoran R et al. *N Engl J Med*. 2018;379:1754-1765; 2. Thierry A et al. *Cancer Metastasis Rev*. 2016;35:347-376.

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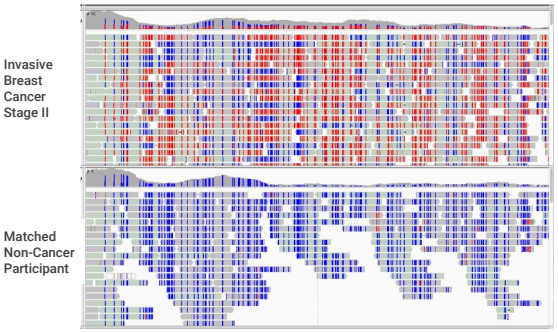
GRAIL's technology is powered by our methylation assay, which preferentially targets informative regions of the genome

Our discovery study showed methylation is a highly informative biological signal for cancer detection and tissue of origin localization



- High cancer detection due to multitude of informative sites compared to other approaches
- Tissue differentiation is driven by methylation, hence patterns are informative for tissue of origin
- Largest known methylation sequence data set for cancer and non-cancer

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Source: Presented at AACR 2018: Aravanis et al., Abstract LB-343; Data on file

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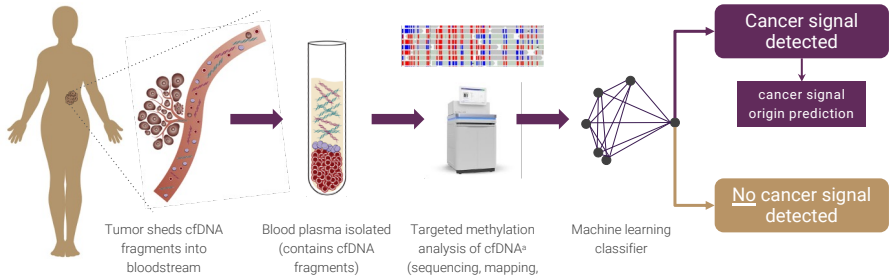
Process Overview of Multi-Cancer Early Detection With Galleri® Test

Cancer can be anywhere: using a targeted methylation, next-generation sequencing (NGS)-based assay analyzing cfDNA and machine learning to detect cancer and predict cancer signal origin



cfDNA, cell-free DNA. [a]Bisulfite treatment; targeted probes pull out fragments matching regions of interest.
The Galleri® test does not detect all cancers and should be used in addition to routine cancer screening tests recommended by a healthcare provider.
Adapted from Liu MC, et al. *Ann Oncol*. 2020;31(6):745-759. DOI:10.1016/j.annonc.2020.02.011.
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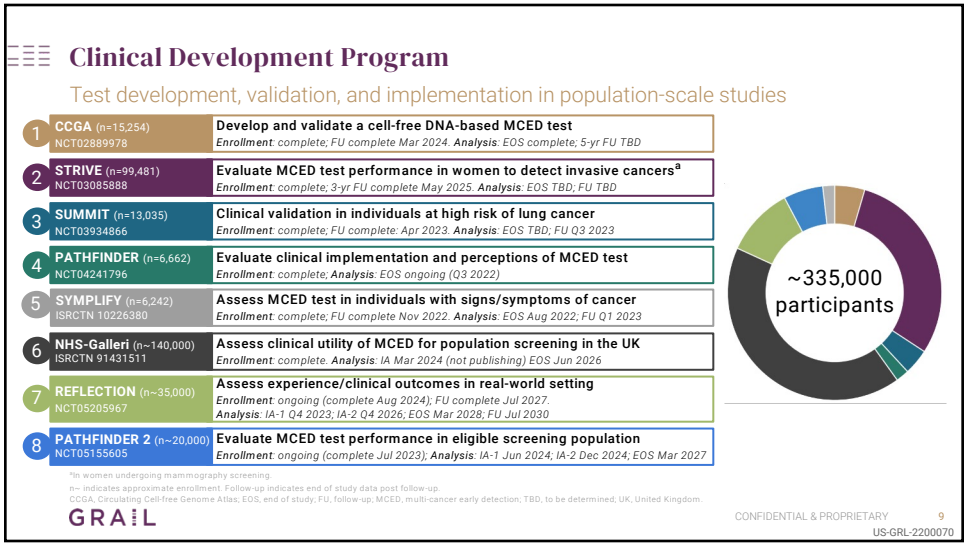
Clinical Development Program
Test development, validation, and implementation in population-scale studies
1 CCGA (n=15,254) NCT02889978
Develop and validate a cell-free DNA-based MCED test
Enrollment: complete; FU complete Mar 2024. Analysis: EOS complete; 5-yr FU TBD
2 STRIVE (n=99,481) NCT03085888
Evaluate MCED test performance in women to detect invasive cancers[a]
Enrollment: complete; 3-yr FU complete May 2025. Analysis: EOS TBD; FU TBD
3 SUMMIT (n=13,035) NCT03934866
Clinical validation in individuals at high risk of lung cancer
Enrollment: complete; FU complete: Apr 2023. Analysis: EOS TBD; FU Q3 2023
4 PATHFINDER (n=6,662) NCT04241796
Evaluate clinical implementation and perceptions of MCED test
Enrollment: complete; Analysis: EOS ongoing (Q3 2022)
5 SYMPLIFY (n=6,242) ISRCTN 10226380
Assess MCED test in individuals with signs/symptoms of cancer
Enrollment: complete; FU complete Nov 2022. Analysis: EOS Aug 2022; FU Q1 2023
6 NHS-Galleri (n~140,000) ISRCTN 91431511
Assess clinical utility of MCED for population screening in the UK
Enrollment: complete. Analysis: IA Mar 2024 (not publishing) EOS Jun 2026
7 REFLECTION (n~35,000) NCT05205967
Assess experience/clinical outcomes in real-world setting
Enrollment: ongoing (complete Aug 2024); FU complete Jul 2027.
Analysis: IA-1 Q4 2023; IA-2 Q4 2026; EOS Mar 2028; FU Jul 2030
8 PATHFINDER 2 (n~20,000) NCT05155605
Evaluate MCED test performance in eligible screening population
Enrollment: ongoing (complete Jul 2023); Analysis: IA-1 Jun 2024; IA-2 Dec 2024; EOS Mar 2027
~335,000 participants
[a]In women undergoing mammography screening.
n~ indicates approximate enrollment. Follow-up indicates end of study data post follow-up.
CCGA, Circulating Cell-free Genome Atlas; EOS, end of study; FU, follow-up; MCED, multi-cancer early detection; TBD, to be determined; UK, United Kingdom.
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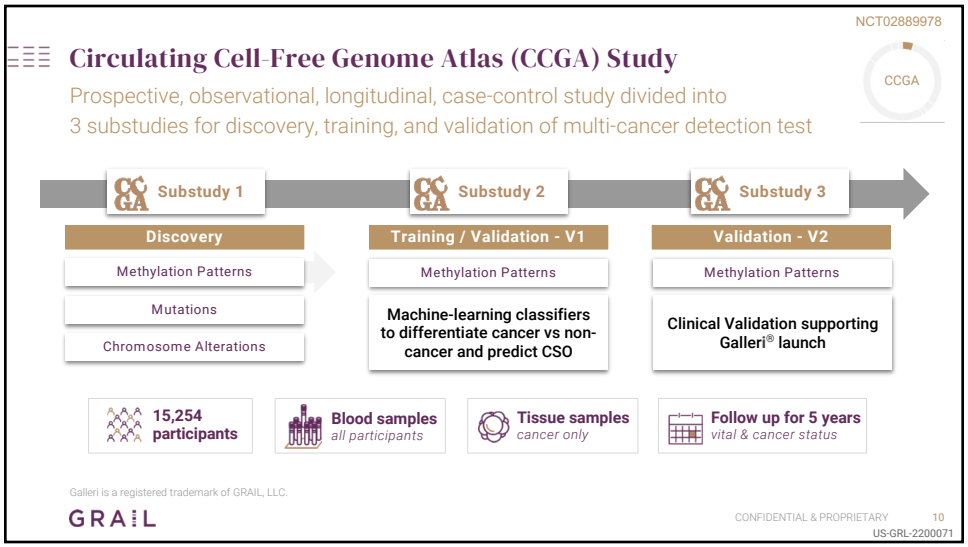
NCT02889978
CCGA
Circulating Cell-Free Genome Atlas (CCGA) Study
Prospective, observational, longitudinal, case-control study divided into
3 substudies for discovery, training, and validation of multi-cancer detection test
Substudy 1
Substudy 2
Substudy 3
Discovery
Methylation Patterns
Mutations
Chromosome Alterations
Training / Validation - V1
Methylation Patterns
Machine-learning classifiers to differentiate cancer vs non-cancer and predict CSO
Validation - V2
Methylation Patterns
Clinical Validation supporting Galleri® launch
15,254 participants
Blood samples all participants
Tissue samples cancer only
Follow up for 5 years vital & cancer status
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Key Performance Features of Multi-Cancer Early Detection Test

Demonstrated in CCGA substudy 3

- **> 50** MCED test detected a cancer signal across more than 50 AJCC cancer types
- **44%** Positive predictive value[a]
- **0.5%** False-positive rate
- **41%** Sensitivity stages I-III for all cancer[b]
- **68%** Sensitivity stages I-III for 12 prespecified cancers representing ⅔ of cancer mortality in US
- **89%** Rate of cancer signal origin predicted correctly[c]

A cancer signal detected across > 50 cancers, including unscreened cancers such as:

- Anus
- Corpus uteri (2 types[d])
- Esophagus[e]
- Exocrine pancreas
- Gallbladder
- Hodgkin and non-Hodgkin lymphoma
- Bile duct (3 types[f])
- Kidney
- Larynx
- Leukemia
- Liver
- Melanoma of the skin
- Malignant pleural mesothelioma
- Merkel cell carcinoma
- Nasopharynx
- Neuroendocrine (3 types[g])
- Oral cavity
- Oropharyngeal[h]
- Oro- and hypo-pharynx[i]
- Ovary[j]
- Plasma cell myeloma[k]
- Renal pelvis and ureter
- Soft tissue sarcoma (5 types[l])
- Small intestine
- Stomach
- Testis
- Urinary bladder
- Vagina
- Vulva

Recommended screening programs[m]

Breast | Cervix uteri | Colon and rectum | Lung | Prostate

[a]Estimated values were adjusted to SEER (Surveillance, Epidemiology, and End Results) cancer incidence and stage distribution in the 50–79 years age group. [b]Including missing stage and cancer classes that do not have staging per AJCC staging manual. [c]For cancer participants with a positive cancer signal. [d]Corpus uteri carcinoma and carcinosarcoma; Corpus uteri sarcoma. [e]Esophagus and esophagogastric junction.[f]Distal bile duct; Perihilar ducts; Intrahepatic bile ducts. [g]Neuroendocrine tumors of the appendix; Neuroendocrine tumors of the colon and rectum; Neuroendocrine tumors of the pancreas. [h]HPV-mediated (p16+) oropharyngeal cancer. [i]Oropharynx (p16-) and hypopharynx. [j]Ovary, fallopian tube and primary peritoneal carcinoma. [k]Plasma cell myeloma and plasma cell disorders. [l]Soft tissue sarcoma: of the abdomen and thoracic visceral organs; of the head and neck; of the retroperitoneum; of the trunk and extremities; unusual histologies and sites. [m]USPSTF A, B, or C rating.
AJCC, American Joint Committee on Cancer; CCGA, Circulating Cell-free Genome Atlas; USPSTF, United States Preventive Services Task Force.
GRAIL data on file GA_2021_008 and Klein E, et al. *Ann Oncol*. 2021;32(9):1167-1177. DOI: 10.1016/j.annonc.2021.05.806.

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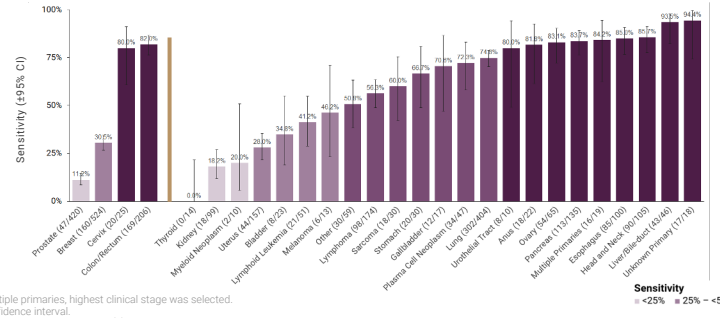
Sensitivity of Cancer Signal Detection Was Higher Overall in Cancers Without Common Screening Versus Those With Common Screening

CCGA Substudy 3

With Common Screening Options:
33.7% (95% CI: 31.1–36.5%)

Without Common Screening Options:
63.8% (95% CI: 61.4–66.1%)



For multiple primaries, highest clinical stage was selected.
CI, confidence interval.
Klein E, et al. *Ann Oncol*. 2021;32(9):1167-1177. DOI: 10.1016/j.annonc.2021.05.806.

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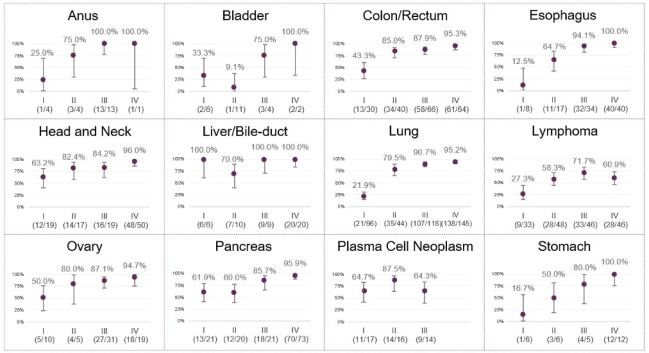
Sensitivity of Cancer Signal Detection by Stage in 12 Pre-Specified Cancers Responsible for Two-Thirds of Cancer Deaths

CCGA Substudy 3



List of 12 cancers that account for 62% of US cancer deaths from American Cancer Society. Cancer Facts & Figures 2021. Atlanta: American Cancer Society; 2021. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2021/cancer-facts-and-figures-2021.pdf. Klein E, et al. *Ann Oncol*. 2021;32(9):1167-1177. DOI: 10.1016/j.annonc.2021.05.806.

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Significant Challenges Exist for Single-Cancer Screening

Cancer	Prevalence (%)	USPSTF Recommended Screening	Compliance With Recommended Screening (%)[6]	Sensitivity (%)	Specificity (%)	Positive Predictive Value (%)	False Positives Per 1,000 People#
Breast[1]	0.6	Biennial mammography, women ages 50–74	78.3	87	89	4.4	110
Cervical[2]	<0.1	Triennial cytology or quinquennial cytology/HPV test, women ages 21–65	77.7	95	85.5	<1*	145
Colorectal[3]	0.65	Decennial colonoscopy	74.2	*Reference*	*Reference*	*Reference*	
		Triennial stool-based screening (Cologuard)		92.3	86.6	3.7*	134
		Annual stool-based screening (FIT)		73.8	94.9	8.7	51
		Ages 45–75 (USPSTF A/B) and 76–85 (USPSTF C)[7]					
Lung[4]	1.1 (high risk)†	Annual low-dose CT for high-risk persons ages 50–80[5]	5†	85†	87†	6.9†	130

CT, computed tomography; FIT, fecal immunochemical test; HPV, human papillomavirus; USPSTF, United States Preventive Services Task Force.
*Pre-cancerous lesions were excluded. †Based on previous USPSTF recommendations of adults 55–80 years with a 30 pack/year smoking history. #Calculated by using inverse of specificity value and multiplying by 10.
[1]USPSTF. 2016. Lehman, et al. *Radiology*. 2017;283(1):49-58. [2]Kim, et al. *JAMA*. 2018;320(7):706-714. [3]USPSTF. 2017. United States Food and Drug Administration Premarket Approval P130017. Accessed March 26, 2019. Cologuard Test. Available from www.cologuardtest.com/hcp/crc-screening-redefined. Accessed March 26, 2019. [4]Pinsky, et al. *Ann Intern Med*. 2015 Apr 7;162(7):485–491. [5]Meza R, et al. *JAMA*. 2021;325(10):988–997. Recommendation for lung screening limited to high-risk smoking population, which accounts for less than 33% of all lung cancers. [6]Compliance from BRFSS Prevalence & Trends Data. 2020. [accessed Dec. 8, 2021]. URL: https://www.cdc.gov/brfss/brfssprevalence/, except LDCT from Fedewa et al. *J Natl Cancer Inst*. 2021;113(8):1044-1052. doi: 10.1093/jnci/djaa170. Data on file GA-2021-0065. [7]https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening#bootstrap-panel--6. Accessed October 13, 2021. Data on file. GA-2021-0069.

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Relatively low PPV and specificity for many single cancer screening tests

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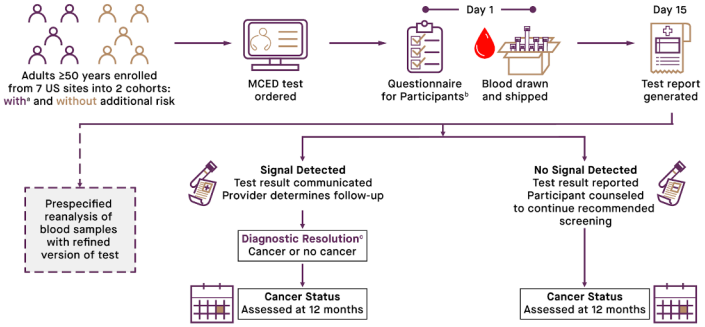
PATHFINDER | Study Design

Prospective, multicenter, interventional, return-of-results study (NCT04241796)



MCED, multi-cancer early detection. [a]Previous history of cancer, smoking, and genetic risk; [b]Also collected at other time points during the study; [c]Defined as date when study team determines to end diagnostic evaluation triggered by a "signal detected" test result. Schrag D, et al. Presentation at European Society for Medical Oncology (ESMO) Congress; September 9-13, 2022.

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PATHFINDER | Study Population

Includes Adults ≥50 years With and Without Additional Cancer Risk

Adults ≥50 years of age

Cohort A: With Additional Risk[a]

Participants with additional risk factors based on:

- History of smoking (≥100 cigarettes)
- Genetic cancer predisposition[b]
- Prior cancer with treatment completed >3 years ago (excluding adjuvant hormone therapy)[c,d]

Cohort B: Without Additional Risk

Participants with none of the additional risk factors described in Cohort A

Key exclusion criteria:

- Undergoing or referred for diagnostic evaluation due to clinical suspicion for cancer
- History of or treatment for invasive/hematologic malignancy *within* 3 years prior to enrollment date (or diagnosed >3 years but never treated)[d]

All PATHFINDER participants are ≥50 years and would be considered to have a higher cancer risk than a general screening population, which may include those <50 years.
[a]The study target was to enroll approximately 70% of the study population as Cohort A, which is expected to enrich the study population for the number of cancer diagnoses.
[b]Documented genetic cancer predisposition, hereditary cancer syndrome, or meeting criteria for germline testing based on current National Comprehensive Cancer Network guidelines.
[c]Personal history of invasive or hematologic malignancy, with definitive treatment completed >3 years prior to enrollment.
[d]Adjuvant hormone therapy for cancer (e.g., for breast or prostate cancer) is permissible (i.e., may be ongoing within 3 years or at the time of enrollment).
Schrag D, et al. Presentation at European Society for Medical Oncology (ESMO) Congress; September 9-13, 2022.

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PATHFINDER | Study Objectives

Primary

Assess extent of diagnostic testing required to achieve diagnostic resolution following a "signal detected" test result

Per Participant:

- ➔ Number of imaging tests and invasive test/procedures
- ➔ Number of clinical lab visits (Including blood and urine collection) and lab tests
- ➔ Number of clinic visits
- ➔ Time required to achieve diagnostic resolution defined as the number of days from when the test result is returned through the reporting portal to the date of diagnostic resolution

Secondary

Evaluate Test Performance:

Cancer Detection

- ➔Resolution per MCED test
- ➔Positive predictive value (PPV)
- ➔Negative predictive value (NPV)
- ➔Specificity

Signal Origin Prediction

- ➔Return rate
- ➔Overall accuracy

Assess participant-reported outcomes and perceptions about the MCED test

➔**Satisfaction, Perceptions** of MCED results, **Health-related quality of life** and **Anxiety** following MCED

GRAIL Schrag D, et al. Presentation at European Society for Medical Oncology (ESMO) Congress; September 9-13, 2022. CONFIDENTIAL & PROPRIETARY 17

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PATHFINDER | Cancers Diagnosed After a True Positive MCED Signal

Early MCED Test

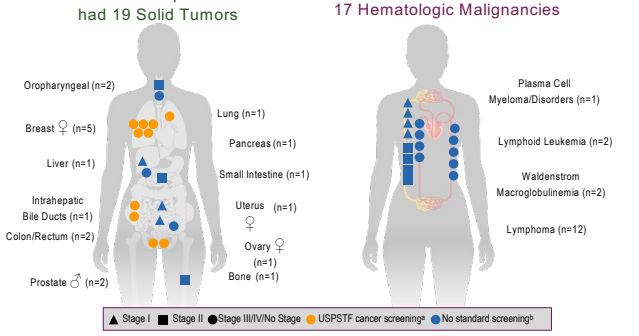
36 Cancers in 35 Participants, including 27 cancers not routinely screened for

18 Participants had 19 Solid Tumors

17 Participants had 17 Hematologic Malignancies

MCED-Detected Cancers

- n=24 in elevated risk cohort
- n=11 in non-elevated risk cohort
- **n=14/29 (48%) of those with non-recurrent cancers had early stage (I/II) diagnoses**
- **n=25/35 (71%) for which there is no standard screening**



[a] Tumor types shown in orange include those for which the US Preventive Services Task Force (USPSTF) advises screening and includes breast, cervical, colorectal, prostate and lung cancer. However, the lung cancer diagnosed was identified in an individual who did not meet USPSTF guidelines and therefore is unlikely to have been screened. [b] Malignancies shown in blue are those for which there is no standard screening per the USPSTF. Schrag D, et al. Presentation at European Society for Medical Oncology (ESMO) Congress; September 9-13, 2022.Galleri is a registered trademark of GRAIL, Inc.

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PATHFINDER | 67% of new cancers were diagnosed in Stage I-III

Refined MCED TEST

Cancer Type Diagnosed	Clinical AJCC Stage (New Cancers)					Recurrent Cancers	First Predicted Cancer Signal Origin
	I	II	III	IV	NA[a]	Distant	
Breast						5	Breast
Colon or rectum				2			Colon/Rectum
Endometrium (Uterus)	1						Breast
Head and Neck		1		1			Head and Neck
Liver or intrahepatic bile duct	1		1				Liver, bile-duct
Lung			1				Lung
Lymphoid leukemia					1		Lymphoid Neoplasm
Lymphoma	1	1	1	1			Lymphoid Neoplasm
Ovary, peritoneum, or FT			2				Ovary; Uterus
Pancreas		1					Pancreas/Gallbladder
Plasma cell neoplasm					1		Plasma Cell Neoplasm
Prostate			1				Breast
Sarcoma		1					Sarcoma
Small intestine	1						Colon/Rectum[b]
Waldenstrom macroglobulinemia					1		Plasma Cell Neoplasm
Total	**4**	**4**	**6**	**4**	**3**	**5**	

No current screening available

Incorrect CSO

21/26 (81%) of cancers diagnosed were de novo and 5/26 (19%) were recurrent

AJCC, the American Joint Committee on Cancer 8th edition Cancer Staging Manual; FT, fallopian tube; GI, gastrointestinal; MCED, multi-cancer early detection test refined for screening; NA, not applicable.
[a]No AJCC stage expected. [b]Small intestine is an untrained cancer not included in a CSO label. GRAIL Data on File GR-2022-0086. EOS analysis

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PATHFINDER | Cancer Diagnosis Was Expedient (Even During COVID-19)

Early MCED Test

Diagnostic resolution was faster for true positives

	True Positives 33[a]	False Positives 57[b]	Total 90[a]
Diagnostic Resolution, Median Days (Q1, Q3)	57 (33, 143)	162 (44, 248)	79 (37, 219)
Number of Participants With Planned Reevaluation at >=3 Month Interval	6	25	31

- Median time to diagnostic resolution was longer for false positives than true positives
- 73% of true positives reached resolution in less than 3 months
- 50% of those true positives cancers were diagnosed in 2 months or less
- Planned reevaluation intervals of 3 months or longer were more common in false positives, likely reflecting repeat or scheduled follow-up testing

[a]Two participants with 'signal detected' MCED test result (TPs) were excluded from the diagnostic workup analysis because diagnostic testing was initiated before MCED results were returned.
[b]Includes 1 participant without diagnostic resolution who was conservatively assumed to be FP.
MCED, multi-cancer early detection.Schrag D, et al. Presentation at European Society for Medical Oncology (ESMO) Congress; September 9-13, 2022. Galleri is a registered trademark of GRAIL, Inc.

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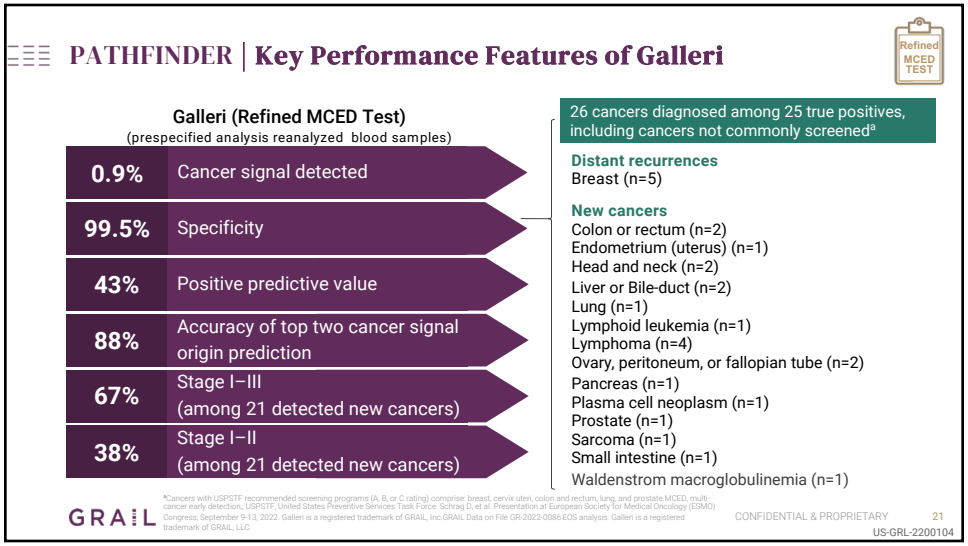
PATHFINDER | Key Performance Features of Galleri
Refined MCED TEST
Galleri (Refined MCED Test)
(prespecified analysis reanalyzed blood samples)
0.9% Cancer signal detected
99.5% Specificity
43% Positive predictive value
88% Accuracy of top two cancer signal origin prediction
67% Stage I–III (among 21 detected new cancers)
38% Stage I–II (among 21 detected new cancers)
26 cancers diagnosed among 25 true positives, including cancers not commonly screened[a]
Distant recurrences
Breast (n=5)
New cancers
Colon or rectum (n=2)
Endometrium (uterus) (n=1)
Head and neck (n=2)
Liver or Bile-duct (n=2)
Lung (n=1)
Lymphoid leukemia (n=1)
Lymphoma (n=4)
Ovary, peritoneum, or fallopian tube (n=2)
Pancreas (n=1)
Plasma cell neoplasm (n=1)
Prostate (n=1)
Sarcoma (n=1)
Small intestine (n=1)
Waldenstrom macroglobulinemia (n=1)
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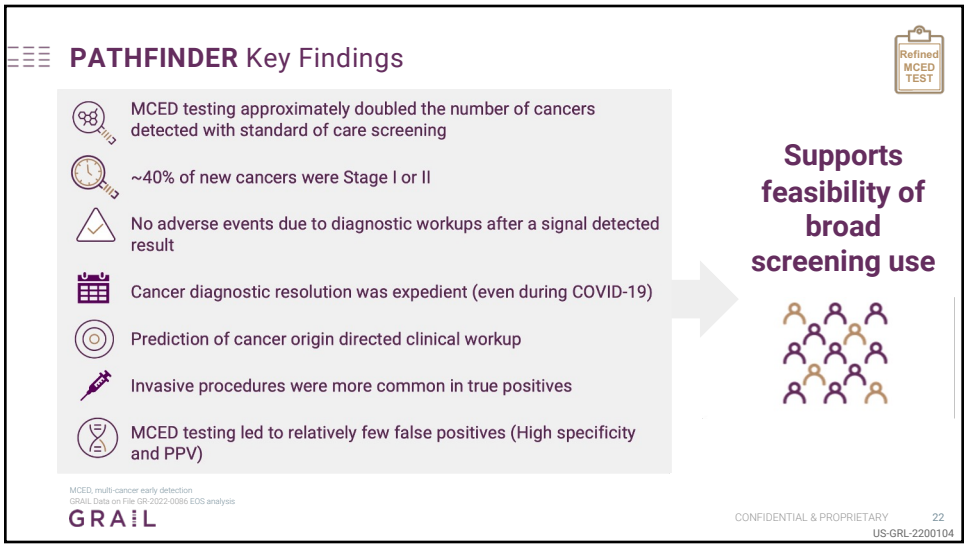
PATHFINDER Key Findings
Refined MCED TEST
MCED testing approximately doubled the number of cancers detected with standard of care screening
~40% of new cancers were Stage I or II
No adverse events due to diagnostic workups after a signal detected result
Cancer diagnostic resolution was expedient (even during COVID-19)
Prediction of cancer origin directed clinical workup
Invasive procedures were more common in true positives
MCED testing led to relatively few false positives (High specificity and PPV)
Supports feasibility of broad screening use
MCED, multi-cancer early detection
GRAIL Data on File GR-2022-0086 EOS analysis
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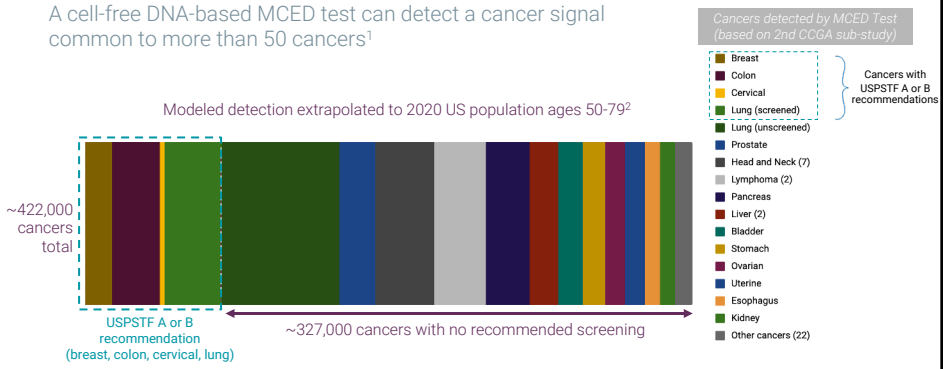
Detecting Cancers Not Found by Standard of Care Today

A cell-free DNA-based MCED test can detect a cancer signal common to more than 50 cancers[1]



CCGA, Circulating Cell-free Genome Atlas study (NCT02889978); MCED, multi-cancer early detection; SEER, Surveillance, Epidemiology, and End Results; US, United States; USPSTF, United States Preventive Services Task Force. [1]Hackshaw A, et al. *Br J Cancer*. 2021;125(10):1432-1442. DOI: 10.1038/s41416-021-01498-4. [2]Data on file GA_2021_010. Calculated by internal analysis using data from SEER*Stat Database: Incidence which represents 34.6% of US population - SEER 18 Regs Research Data, Nov 2018 Submission. Includes persons aged 50-79 diagnosed 2006-2015 and CCGA substudy 2 (methylation training and test) performance. Screening includes methods with United States Preventive Services Task Force (USPSTF) A or B rating. Subject to important limitations; including the assumption that CCGA substudy 2 results[1] are generalizable to a real-world population similar to the Surveillance, Epidemiology, and End Results (SEER) registry.

This slide allows us to see the number of cancers involved. Galleri is modeled to find 327k cancers per year with no recommended screening

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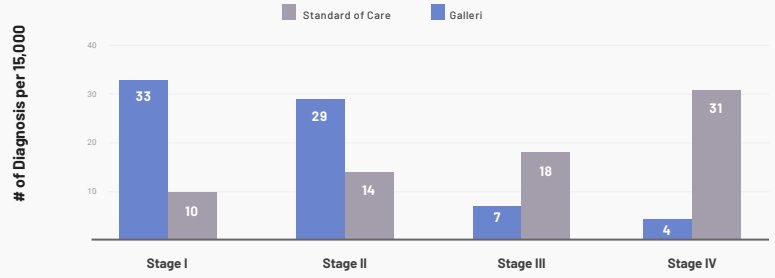
Galleri has the potential to shift cancer detection to earlier stages[1]



*In cancers detected by GRAIL's MCED test.
1Hubbell, et al. OnlineFirst Publication. 2020;10.1158/1055-9965.EPI-20-1134.

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Galleri Test Experience in Clinical Practice

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100,000 tests completed, 7,100+ prescribing physicians across the U.S.

Galleri test experience in clinical practice:

Cancer signal detection rate as expected for an intended use population[1]

0.9%
of test results were Cancer Signal Detected

99.1%
of test results were No Cancer Signal Detected

True cancer status for these results is unknown. A test result of "No Cancer Signal Detected" does not rule out cancer. A test result of "Cancer Signal Detected" requires confirmatory diagnostic evaluation by medically established procedures (e.g. imaging) to confirm cancer. The Galleri test does not detect a signal for all cancers and not all cancers can be detected in the blood. False positive and false negative results do occur.

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1. National Cancer Institute. Age and Cancer Risk: Incidence rates by age at diagnosis, all cancer types. SEER 21 2013–2017, all races, both sexes. Adults with increased risk for cancer.
Data on file GA-2022-0078. First 100,000 tests included Galleri prescribed outside of intended use.

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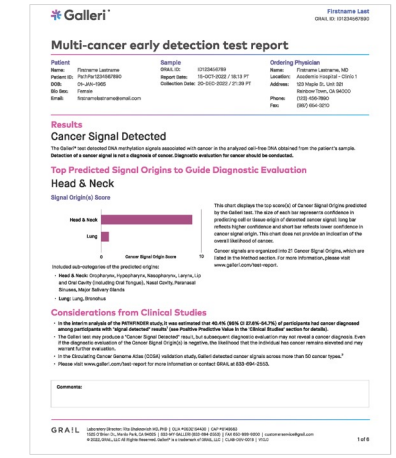
Cancer Signal Detected: Pages 1 & 2


Galleri®

Firstname Last
ORAIL ID: 101234567890

Multi-cancer early detection test report

Patient
Name: Firstname Lastname
Patient ID: PatTrfle123456789O
DOB: 04-JAN-1965
Bio Sex: Female
Email: firstnamelastname@email.com

Sample
GRAIL ID: 101234567890
Report Date: 15-OCT-2022 / 18:13 PT
Collection Date: 20-SEP-2022 / 21:39 PT

Ordering Physician
Name: Firstname Lastname, MD
Location: Academia Hospital - Clinic 1
Address: 123 Maple St., Unit 321
Rainbow Town, CA 94000
Phone: (123) 456-7890
Fax: (987) 654-3210

Results

Cancer Signal Detected

The Galleri® test detected DNA methylation signals associated with cancer in the analyzed cell-free DNA obtained from the patient's sample.
Detection of a cancer signal is not a diagnosis of cancer. Diagnostic evaluation for cancer should be conducted.

Top Predicted Signal Origins to Guide Diagnostic Evaluation

Head & Neck

Signal Origin(s) Score

This chart displays the top score(s) of Cancer Signal Origins predicted by the Galleri test. The size of each bar represents confidence in predicting cell or tissue origin of detected cancer signal: long bar reflects higher confidence and short bar reflects lower confidence in cancer signal origin. This chart does not provide an indication of the overall likelihood of cancer.

Cancer signals are organized into 21 Cancer Signal Origins, which are listed in the Method section. For more information, please visit www.galleri.com/test-report.

Included sub-categories of the predicted origins:
- **Head & Neck:** Oropharynx, Hypopharynx, Nasopharynx, Larynx, Lip and Oral Cavity (including Oral Tongue), Nasal Cavity, Paranasal Sinuses, Major Salivary Glands
- **Lung:** Lung, Bronchus

Considerations from Clinical Studies

- **In the interim analysis of the PATHFINDER study,1 was estimated that 40.4% (95% CI 37.6%-44.7%) of participants had cancer diagnosed among participants with "signal detected" results' (see Positive Predictive Value in the 'Clinical Studies' section for details).**
- The Galleri test may produce a "Cancer Signal Detected" result, but subsequent diagnostic evaluation may not reveal a cancer diagnosis. Even if the diagnostic evaluation of the Cancer Signal Origin(s) is negative, the likelihood that the individual has cancer remains elevated and may warrant further evaluation.
- In the Circulating Cancer Genome Atlas (CCGA) validation study, Galleri detected cancer signals across more than 50 cancer types.2
- Please visit www.galleri.com/test-report for more information or contact GRAIL at 833-694-2553.

Comments:

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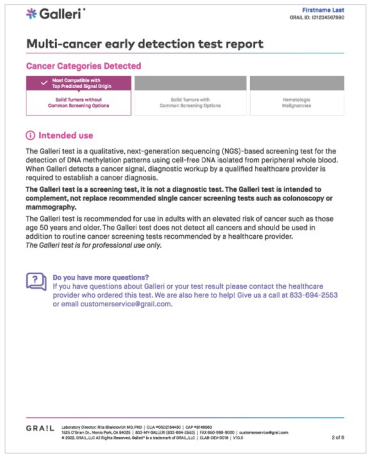
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ORAIL ID: 101234567890

Multi-cancer early detection test report

Cancer Categories Detected

Most Compatible with Top Predicted Signal Origin		
Solid Tumors without Common Screening Options	Solid Tumors with Common Screening Options	Hematologic Malignancies

Intended use

The Galleri test is a qualitative, next-generation sequencing (NGS)-based screening test for the detection of DNA methylation patterns using cell-free DNA isolated from peripheral whole blood. When Galleri detects a cancer signal, diagnostic workup by a qualified healthcare provider is required to establish a cancer diagnosis.

The Galleri test is a screening test, it is not a diagnostic test. The Galleri test is intended to complement, not replace recommended single cancer screening tests such as colonoscopy or mammography.

The Galleri test is recommended for use in adults with an elevated risk of cancer such as those age 50 years and older. The Galleri test does not detect all cancers and should be used in addition to routine cancer screening tests recommended by a healthcare provider.
The Galleri test is for professional use only.

Do you have more questions?
If you have questions about Galleri or your test result please contact the healthcare provider who ordered this test. We are also here to help! Give us a call at 833-694-2553 or email customerservice@grail.com.

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Thank you

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