

— FARERX

FareRx is a food-first healthcare company.

Clinical nutrition care, medically tailored groceries, and human support for people managing chronic disease.



— THE GAP AND THE MODEL

Most nutrition
care stops at the
recommendation.

Eat differently.
Lose weight.
Control your A1c.
Then the patient goes home.

We put the food
behind the
recommendation.

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|----|------------------------------|----------------------|
| 01 | Clinical nutrition care | Dietitian-led care |
| 02 | Medically tailored groceries | Food at home |
| 03 | Member Hospitality | Human follow-through |

The lesson doesn't end when the appointment does. The food goes home.

90% of the nation's \$5.3T in annual healthcare expenditures are for people with chronic and mental health conditions. Source: CDC, Fast Facts (2026).

— WHY IT WORKS

Food creates a relationship traditional healthcare struggles to build.



Food → Recurring human contact → Trust → Engagement → Clinical relationship

Member Hospitality is the patient-engagement model.

PATIENT

Food access, confidence, support

BUYER

Engagement, adherence, retention, outcomes opportunity

FARERX

Trusted relationship, recurring engagement, longitudinal clinical care

Member Hospitality is FareRx's patient-engagement model. The clinical relationship is a growth opportunity, not an achieved conversion rate.

TRACTION AND OUTCOMES

The model is already working at scale.

15,000+ members served	120,000+ grocery deliveries	99.7% delivery success	4.9 / 5 member satisfaction	~\$1.7M 2026 management revenue outlook
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92%
4-week cohort maintained or improved medication adherence

65%
reported less food stress

61%
tried new healthy foods

72–84%
more likely to stay with their health plan

Current payer: a leading Blue Cross Blue Shield payer.

The 2025 outcomes analysis includes 102 matched pre/post member pairs across four cohorts. Outcome rates shown are supplied in the presentation brief; measures and denominators differ by question and cohort, and do not represent all 15,000+ members served. Self-reported and observational, not claims-based ROI or measured clinical endpoints. Revenue is a management outlook, not full-year actuals.

MARKET AND GROWTH

A ~\$120B market. An ~\$81M obtainable model requires a tiny fraction of it.

TAM

\$120B

~\$19.4B grocery + ~\$100.2B clinical



SAM

\$3.8B

~\$1.15B grocery + ~\$2.65B clinical



SOM

\$81M

~\$12.5M grocery + ~\$68.9M clinical



20,000 clinical patients = <0.1% of Americans with diagnosed diabetes.

Band lengths show progression, not proportional market size. Sources: KFF 2026 Medicare Advantage; CMS April 2026 Medicaid (rounded); CDC 2026 diagnosed diabetes. Eligibility, clinical collections, SAM and SOM are FareRx management assumptions. MA and Medicaid lives may overlap.

REVENUE MODEL AND UNIT ECONOMICS

Revenue expands as the relationship deepens.

Grocery delivery

ACTUAL OPERATING MODEL

Revenue / completed delivery	\$80
Food	– \$25
Direct operating labor	– \$24
CONTRIBUTION 39% contribution margin	\$31

Clinical patient-year

MODELED FULL PLATE

Gross billed	\$4,050
85% modeled collection	\$3,443 net
Direct clinical labor	– \$1,517
MODELED CONTRIBUTION 56% margin · 43–patient modeled break-even ~\$6,924/month modeled fixed clinical cost	\$1,925

CONTRACTED GROCERY PROGRAMS → REIMBURSABLE CLINICAL CARE → PAYER / EMPLOYER PROGRAMS

Grocery contribution is not QBO accounting gross margin. Clinical amounts are modeled from CY2026 reimbursement assumptions and have not yet been proven through claims history. No PMPM structure is assumed.

COMPETITIVE POSITIONING

FareRx connects food delivery and longitudinal clinical care through one patient relationship.



Most models begin with either food or clinical care.

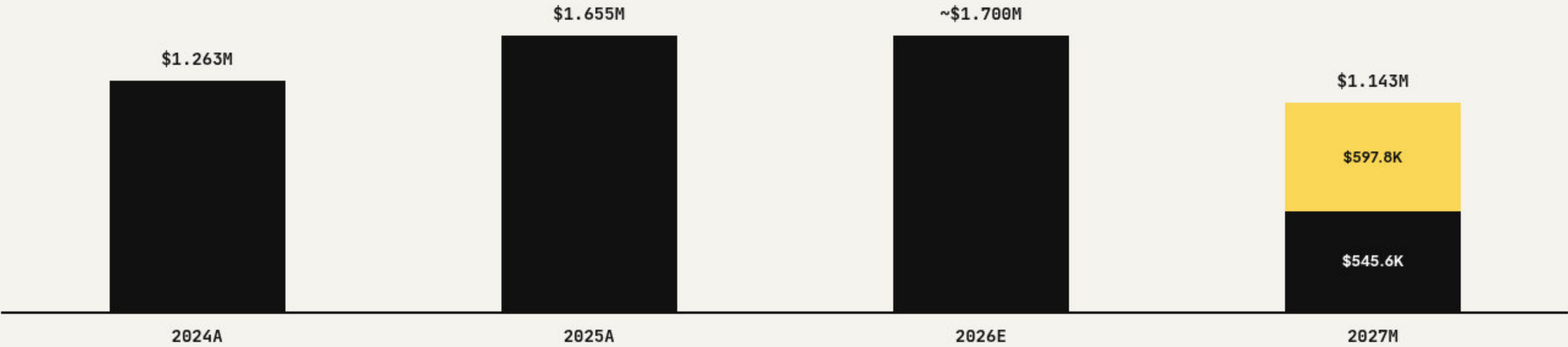
FareRx connects the two through one patient relationship.

Illustrative positions reflect publicly described primary focus, not a claim that other companies cannot offer adjacent services. Foodsmart and Season Health also connect care and food benefits; Mom's Meals offers nutrition counseling alongside meals.

FINANCIAL PERFORMANCE

Bootstrapped growth. A deliberate shift toward clinical revenue.

GROCERY BENEFIT CLINICAL CLAIMS



From grocery-heavy revenue to a separate clinical census.

The 2027 plan resets the grocery base and models claims revenue. It does not include an acquisition.

MEASURE	2024A	2025A	2026E	2027M
QBO gross margin*	59.6%	66.1%	~70%	~70%
Net income	\$(204K)	\$48K	~\$68K	~\$23K
Net margin	(16.2%)	2.9%	~4%	~2%

2027 is a deliberate bridge year and a planning model, not the long-term revenue trajectory. Clinical enrollment and collections are targets. 2026-27 margins are estimates, not a reconciled budget. QBO gross margin excludes substantial delivery labor booked in operating expenses. Acquisition revenue is excluded.

FIVE-YEAR SCALE MODEL

The new model scales patient census faster than fixed infrastructure.

PATIENTS → EVIDENCE → PAYER / EMPLOYER CONTRACTS → LOWER ACQUISITION COST → MORE PATIENTS

More patients create evidence. Evidence wins distribution. Distribution lowers acquisition cost.

REVENUE AND TARGET NET MARGIN



TARGET NET MARGIN



Clinical relationships	~950*	2.5K	5K	10K	20K
Grocery deliveries / week	~130	500	1K	2K	3K
Teaching kitchens / hubs	1	1	2	3	5

SHARED INFRASTRUCTURE . Compliance, security, technology, payer operations and leadership can scale across more patients.

VARIABLE CAPACITY . Clinical labor, food, delivery and local operations still grow with volume.

Management planning case, illustrative for 2028–2031. Not contracted revenue or financial guidance. *2027 combines MNT conversions and separate Full Plate patient-years; these are not ~950 equivalent longitudinal Full Plate patients. 2028–2031 clinical revenue assumes ~\$3,443 modeled annual net per patient-year; groceries assume \$80 per delivery. No acquisition or unsigned employer-contract revenue included.

— TEAM AND CAPITAL

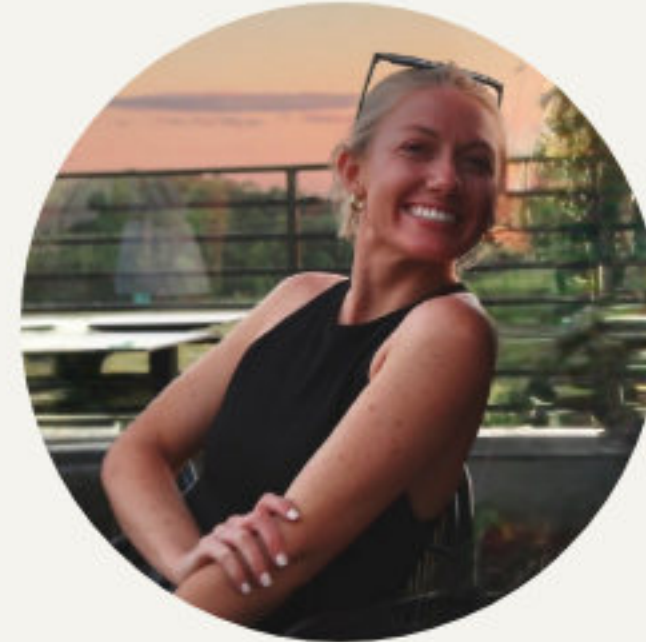
Built by operators. Delivered by clinicians.



Mike Cangi
FOUNDER & CEO



Kenneth Rice, MD
MEDICAL DIRECTOR



Kathryn Oakes, RDN, LDN
CLINICAL NUTRITION LEAD



Jean Fox
PHILADELPHIA OPERATIONS

BOOTSTRAPPED

No outside equity raised \$50K non-dilutive City of Philadelphia grant Working-capital facility supports operations

— DIABETES 250

A defined cohort. A six-month test.

01

Population

Identify a high-risk diabetes cohort with relevant comorbidities; confirm eligibility and baseline measures.

02

Intervention

Coordinate eligible clinical nutrition care with weekly medically tailored groceries and Member Hospitality.

03

Evaluation

At month six, examine enrollment, engagement, clinical measures, patient experience, and utilization where data is available.

Pilot design, not a signed employer contract or proven utilization result.

EVIDENCE

Engagement signals, with the cohort clearly defined.

102 matched pre/post member pairs	92% 4-week cohort maintained or improved medication adherence	65% reported less food stress	61% reported trying new healthy foods
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Across the report's program cohorts, 72–84% said the benefit made them more likely to stay with their health plan.

The FareRx 2025 Outcomes Report includes 102 matched pre/post member pairs; rates shown come from the presentation brief. Questions and cohort denominators differ. Self-reported and observational, not claims-based ROI or demonstrated clinical-marker change.

MARKET SIZING

Two revenue lanes. One addressable opportunity.

TAM	~\$19.4B GROCERY	+	~\$100.2B CLINICAL	=	~\$119.6B FARERX COMBINED
SAM	~\$1.15B GROCERY	+	~\$2.65B CLINICAL	=	~\$3.80B FARERX COMBINED
SOM	~\$12.5M GROCERY	+	~\$68.9M CLINICAL	=	~\$81.4M FARERX COMBINED

GROCERY BASIS

12 weeks x \$80 per member. 20% assumed eligibility for the combined Medicare Advantage and Medicaid baseline; 1.2M initially serviceable lives; 3,000 weekly deliveries at SOM.

CLINICAL BASIS

29.1M Americans with diagnosed diabetes x \$3,443 modeled annual net revenue; ~770K initially serviceable lives; 20,000 patient-years at SOM.

Grocery: 12-week intervention at \$80/week; TAM uses 35.2M MA + rounded 66.0M Medicaid lives x 20% assumed eligibility; SAM uses 1.2M initial PA/NJ/DE lives; SOM uses 3,000 weekly deliveries. Clinical: 29.1M diagnosed diabetes lives x \$3,443 modeled annual net; SAM uses ~770K initial lives; SOM uses 20,000 patient-years. MA and Medicaid can overlap. Sources: KFF, CMS, CDC and FareRx management assumptions.

— GROCERY ECONOMICS

The grocery lane has measured operating contribution.

Per completed delivery

\$80 revenue less \$25 food less \$24 direct operating labor equals \$31 contribution.

Contribution margin

39% rounded. This is an operating contribution measure, not QBO accounting gross margin.

Accounting distinction

QBO gross margin excludes substantial delivery labor booked in operating expenses.

Actual model inputs supplied in the revision brief. Confirm the current model's time period before wider distribution.

— CLINICAL ECONOMICS

The clinical lane is modeled, not yet proven through claims.

Revenue per patient-year

\$4,050 gross billed × 85% modeled collections ≈
\$3,443 net revenue.

Modeled contribution

Less \$1,517 variable cost ≈ \$1,925 contribution; 56%
rounded margin.

Break-even census

43 patients based on approximately \$6,924 per month
in fixed clinical cost.

Modeled from CY2026 reimbursement assumptions. Not yet proven through claims history. Payer eligibility, visits and collections determine realized economics.

— HEALTHCARE READINESS

Built to operate inside healthcare.

01

Clinical

Registered Dietitians, provider NPI, and a Philadelphia Teaching Kitchen.

02

Security

HIPAA-compliant operations and SOC 2 Type II certification.

03

Operations

Member Hospitality, food fulfillment, local delivery, and payer-grade implementation experience.

Specific payer credentialing and reimbursement eligibility depend on service, clinician, plan, and market.



MEMBER HOSPITALITY

Human service is the patient-engagement model.

A human answer by phone, a local delivery experience, and repeated chances to learn what gets in the way of care.

Phone-first access	A real support team
Recurring food touchpoints	Follow-through without an app requirement

Same-driver relationships depend on route and staffing availability; not guaranteed for every member.

— ACQUISITION THESIS

Acquire a head start, not a headline.

A strategic acquisition could reduce the time required to establish a clinical presence in a new market.



The pending strategic acquisition is excluded from the 2027 forecast. Potentially reachable patients are not enrolled patients or guaranteed revenue.

2027 REVENUE BUILD

Clinical claims can offset a smaller grocery base.

GROCERY BENEFIT	~1,700 members x 4 deliveries x \$80	\$545.6K
MNT	850 members x 10.2 completed units x \$29.25	~\$253.6K
SEPARATE FULL PLATE	100 patient-years x \$4,050 gross x 85%	~\$344.3K

2027 modeled total \$1.143M

Planning model only. Current MA cohort MNT eligibility is distinct from the separate Full Plate population; collections and enrollment remain targets. No acquisition revenue is included.