



People. Passion. Purpose.

**Investor Presentation
October 2026**

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Forward-Looking Statements and Other Information

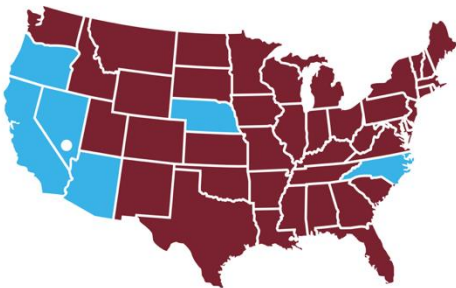
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Important risks and uncertainties that could cause our actual results and financial condition to differ materially from those indicated in forward-looking statements include, among others, our ability to continue as a going concern; our potential need to raise additional capital to fund our existing operations or develop or commercialize new services or expand our operations; our ability to achieve or maintain profitability; our ability to maintain compliance with our debt covenants in the future, or obtain required waivers from our lenders if future operating performance were to fall below current projections of if there are material changes to management's assumptions, we could be required to recognize non-cash charges to operating earnings for goodwill and/or other intangible asset impairment; our ability to identify and develop successful new geographies, physician partners, payors and patients; changes in market or industry conditions, regulatory environment, competitive conditions, and receptivity to our services; our ability to fund our growth and expand our operations; changes in laws and regulations applicable to our business; our ability to maintain our relationships with health plans and other key payers; our ability to establish and maintain effective internal controls and the impact of the material weaknesses we have identified; our ability to maintain the listing of our securities on The Nasdaq Stock Market, LLC, increased labor costs; our ability to recruit and retain qualified team members and independent physicians; and other factors discussed under Part I, Item 1A. “Risk Factors” and Part II, Item 7. “Management’s Discussion and Analysis of Financial Condition and Results of Operations” in our Annual Report on Form 10-K for the year ended December 31, 2025, and in our subsequent filings with the SEC. All information in this presentation is as of the date hereof, and we undertake no duty to update or revise this information unless required by law.

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P3 at a Glance: Why Now



A physician enablement company taking full financial risk for Medicare Advantage members, now profitable at its core

WHO WE ARE

We partner with independent primary care physicians and take responsibility for the total cost of care of their Medicare Advantage patients, earning a share of the premium payers receive.

~105K
at-risk members

~133K
total lives

6
states

2,100+
primary care providers

17
payer partners

\$1.5-1.6B
2026 revenue guidance

WHY NOW

Turnaround delivered

\$95M

2026 Adj. EBITDA guidance midpoint, raised twice this year (from \$10M)

Core business self-funding

\$30M+

Underlying Adj. EBITDA, excluding settlements and prior year items

Balance sheet reset

\$250M

Debt converted to preferred equity in April 2026

Embedded upside

5 levers

Significant untapped value inside the business at existing volumes

Experienced Leadership Team from HealthCare Partners & Optum

Since 2024: payer contracts restructured, network realigned, \$250M recapitalization, core business back to profitability



Joined Q2 2024

Aric Coffman, MD
Chief Executive Officer
20+ years

Built Honest Medical Group to \$1.3B revenue; turned Everett Clinic from (\$10M) to \$38M operating income





Joined Q3 2024

Leif Pedersen
Chief Financial Officer
25+ years

25+ years in healthcare finance, spanning an \$8B health care services provider, \$5B medical group, and a \$1B shared-services P&L

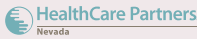




Co-Founder

Amir Bacchus, MD
Co-Founder & Chief Medical Officer
30+ years

Ran HCP Nevada: ~\$125M EBITDA, 52 clinics; cut medical costs 12%+





Joined Q2 2023

Bill Betterman
Chief Operating Officer
25+ years

Optum: \$1B+ Pacific Northwest P&L; COO of Aurora Medical Group (~\$1.2B)





Joined Q1 2025

Todd Smith
Chief Legal & Compliance Officer
25+ years

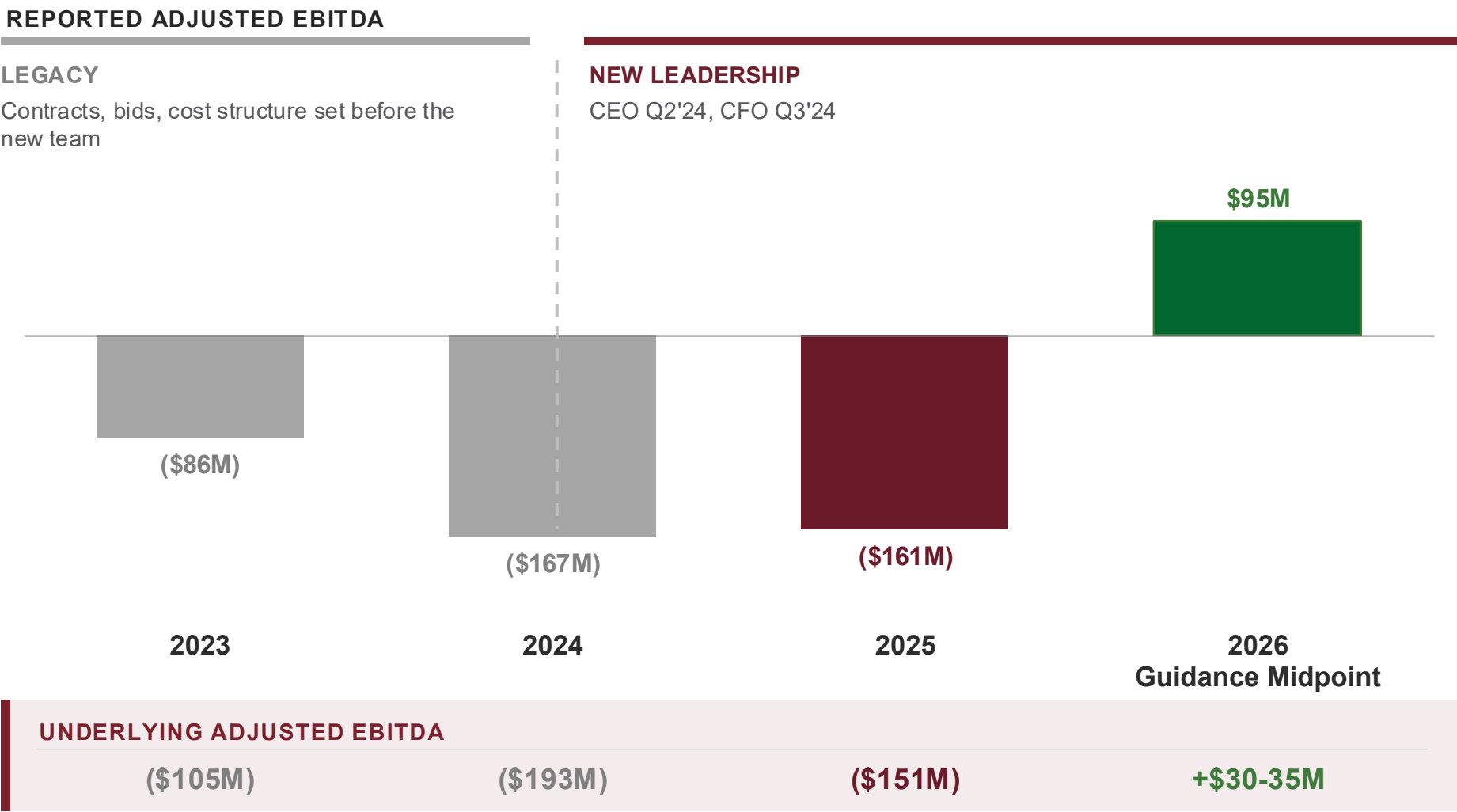
Optum: scaled 3 to 75 markets via M&A and delegated risk; Elevance General Counsel



125+ combined years driving excellence within value-based care organizations at scale

Turnaround Under New Leadership: Sustained Financial Improvement

Judge the team on the years it controlled: a ~\$256M improvement in its first full year



+\$256M

Adjusted EBITDA improvement
2025 actual to 2026 guidance midpoint (\$80–110M)

+\$42M

Underlying Adjusted EBITDA improvement in 2025, the restructuring year

\$18M

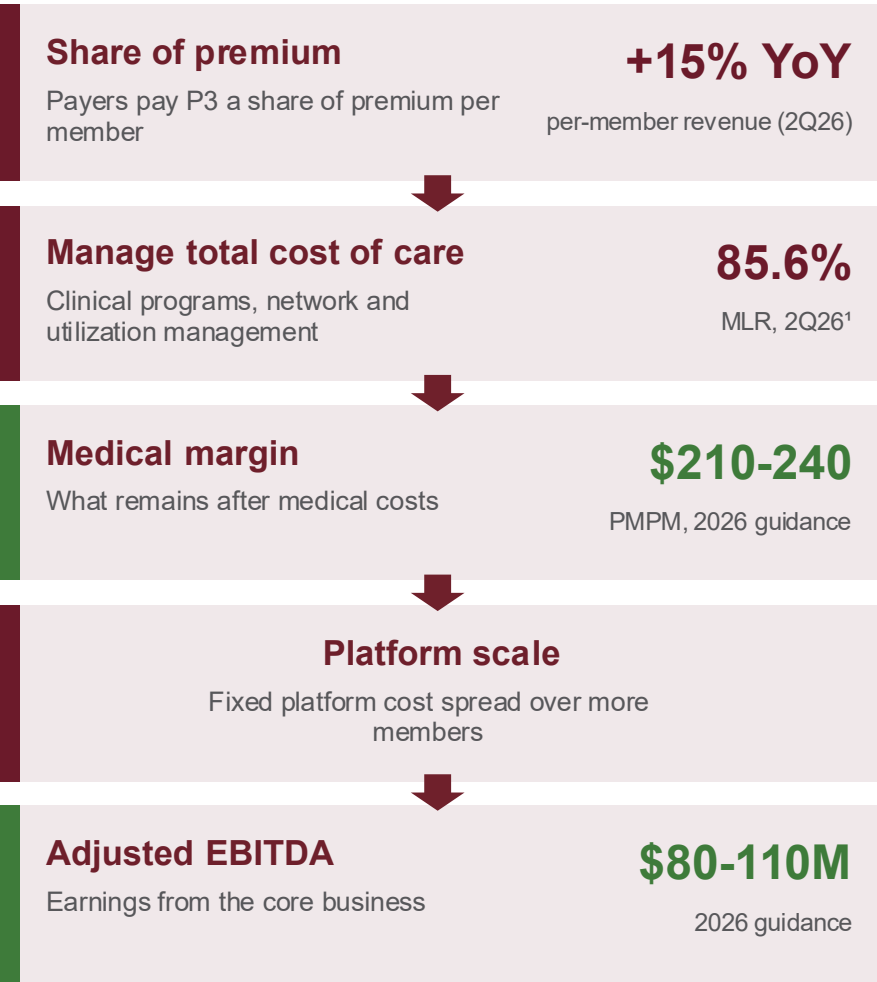
1H26 underlying Adjusted EBITDA: the core business is self-sustaining

Adjusted EBITDA as reported (FY2023 per 4Q23 release; FY2024-25 per 4Q25 release). Underlying per 4Q25 release. 2026G bar at guidance midpoint; includes \$62M of 1H26 payer settlements and prior year development. Adjusted EBITDA is a non-GAAP measure; see appendix.

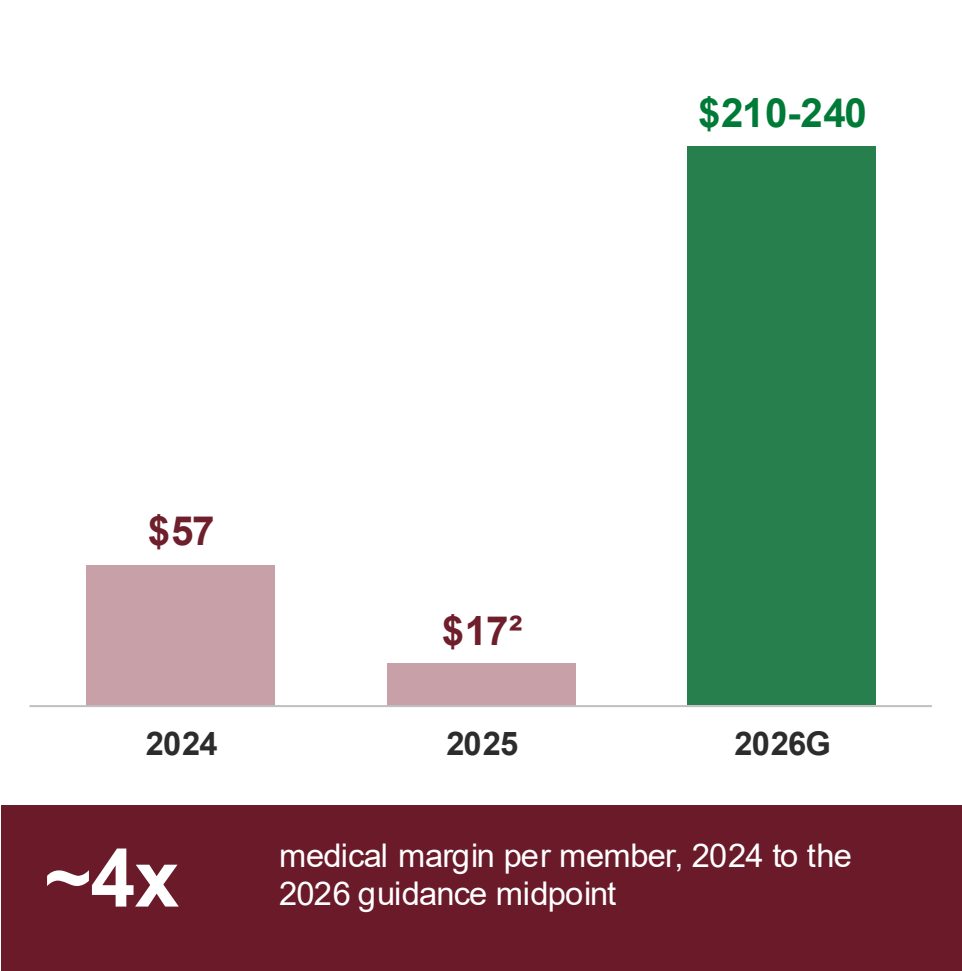
How P3 Makes Money: The Economic Engine

Medical margin is the engine: a growing share of premium, managed cost of care, and leverage from scale

The engine



Medical margin PMPM



What moves each line

Every +\$10 PMPM ≈ +\$12-13M of annual Adjusted EBITDA

Revenue
Burden of illness: +0.01 ≈ ~\$10M annual revenue · Stars quality bonus · % of premium and contract terms

Medical costs
1% lower medical cost ≈ ~\$10 PMPM · UM, network curation, Tier 1 mix, SNF-to-home redirects

Platform costs
Operating leverage as density and membership grow · Delegation and vendor consolidation

(1) Medical loss ratio excluding payer settlements and prior year development, as discussed on the 2Q26 earnings call. (2) FY2025 normalized medical margin: \$38 PMPM. Medical margin PMPM for FY2024-25 per 4Q25 release; 2026G = guidance range, bar at midpoint, includes 1H26 payer settlements and prior year development. Sensitivities are arithmetic at ~105K at-risk members, not forecasts. Medical margin and Adjusted EBITDA are non-GAAP measures; see appendix.

A Recapitalized, Self-Funding Balance Sheet

Debt eliminated, interest cost cut by more than half, and a core business that funds itself

\$250M

debt eliminated

Converted to preferred equity, April 28, 2026

\$17M → \$8M

quarterly net interest expense

1Q26 to 2Q26, after the conversion¹

\$21M + \$70M

cash plus preferred commitments

Cash as of June 30, 2026

~\$100M

payer liabilities resolved

Through negotiated settlements and payments as of June 30, 2026

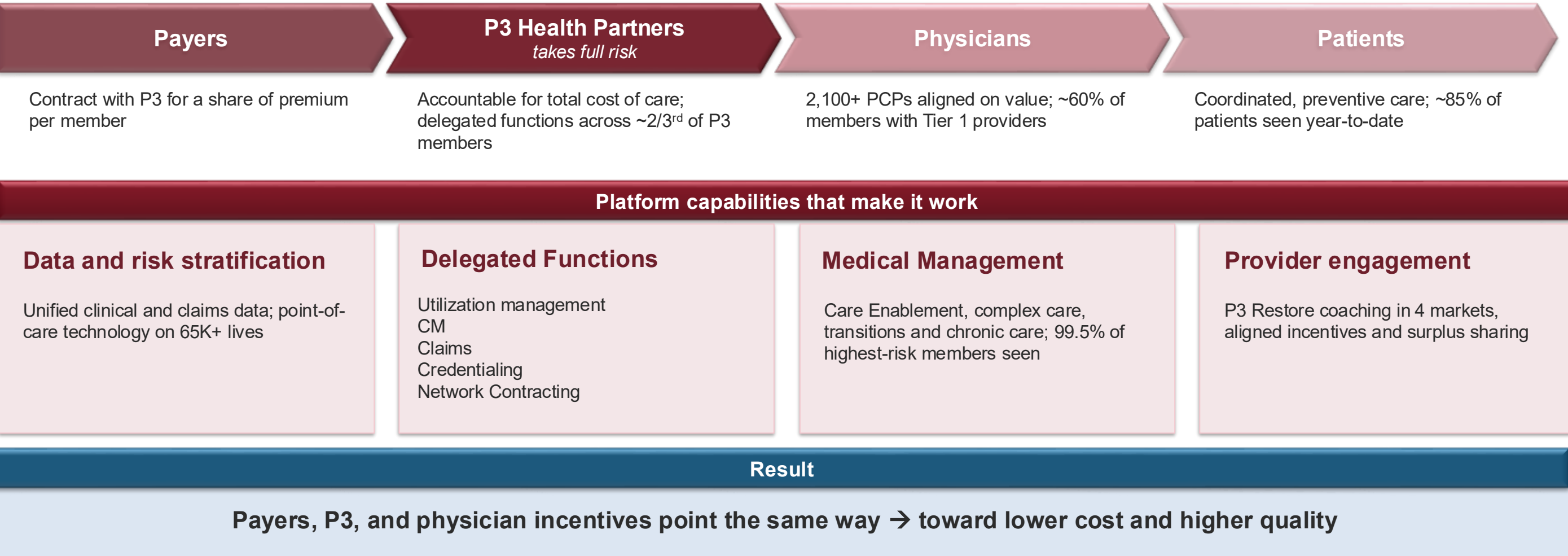
What it means for shareholders

- Lower fixed obligations: \$250M of debt converted to preferred equity; quarterly net interest expense down by more than half
- Self-funding core: ~\$30-35M of 2026 underlying Adjusted EBITDA before settlements and prior-year items
- Liquidity: cash plus remaining preferred commitments, with capital-light growth through delegated market entry
- Transparency: preferred equity terms (dividends, conversion) are detailed in company filings

(1) Net interest expense per company earnings releases; 2Q26 includes approximately one month before the April 27, 2026 conversion. Source: P3 1Q26 and 2Q26 earnings releases and calls; company filings.

How the Model Works

P3 aligns payers, physicians and patients under one full-risk model, supported by a platform built to manage total cost of care



Metrics from P3 1Q26 and 2Q26 earnings calls; 2,100+ PCPs per company data.

Case Study: California, the Model at Work

As the P3 Care Enablement Model matured, inpatient admissions fell 30% and readmissions 26% in our California market

-30%

Inpatient admissions per 1,000

163 (2025 avg) to 114 (2026 YTD)

-26%

Hospital readmission rate

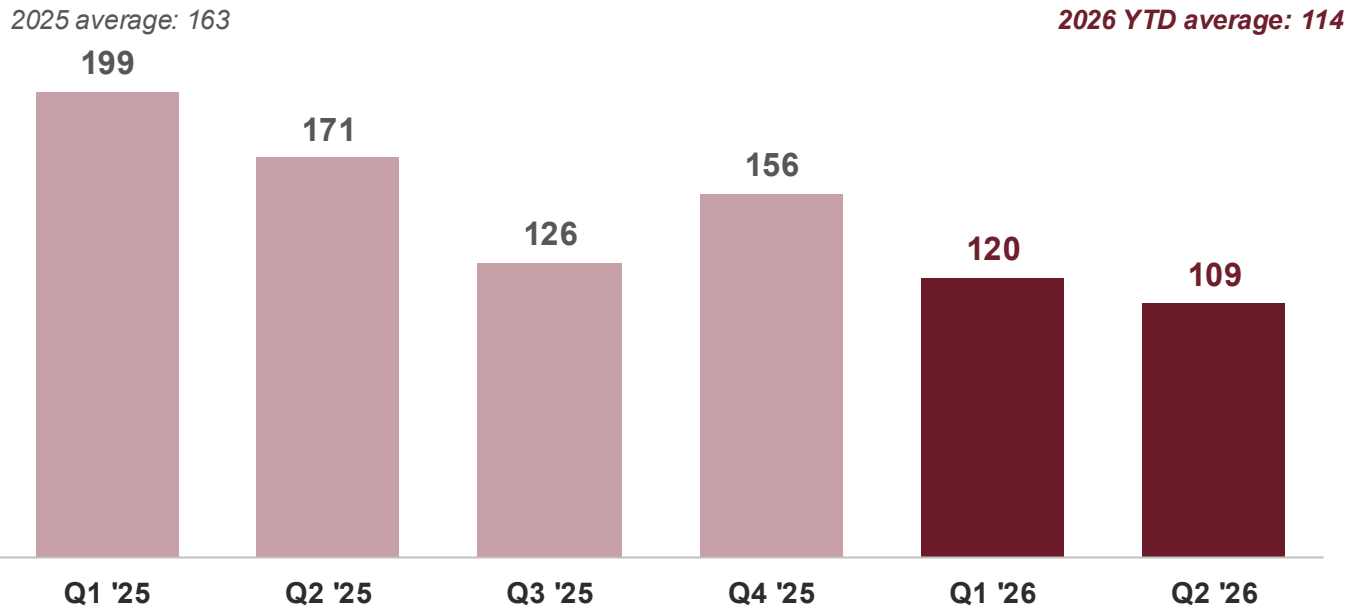
18.8% (2025) to 13.9% (2026 YTD), lowest in three years

-21%

Skilled nursing length of stay

19.2 days (Q3 2025) to 15.2 days (Q2 2026)

Inpatient admissions per 1,000 members, by quarter



How the model drove it

- 1

Proactive primary care

Care coordinators schedule annual wellness and chronic-condition visits before conditions escalate
- 2

Access beyond the ER

Paid after-hours phone visits, telemedicine and urgent care awareness redirect avoidable ER use
- 3

Highest-risk members

RN Clinical Liaisons build PCP-aligned plans, coordinate discharges and goals-of-care referrals
- 4

Post-acute management

Lower-rated skilled nursing facilities removed from network; real-time utilization review with facilities

Why it matters: inpatient and post-acute care are the largest drivers of Medicare Advantage medical cost; 114 vs. 163 admissions per 1,000 is ~49 fewer admissions per 1,000 members a year.

P3 California Medicare Advantage members, excluding commercial and ACO. Periods as labeled; SNF length of stay is quarter-to-quarter. 2026 data are year-to-date and subject to claims run-out. Source: P3 internal utilization reporting.

How We Execute: The Operating Playbook

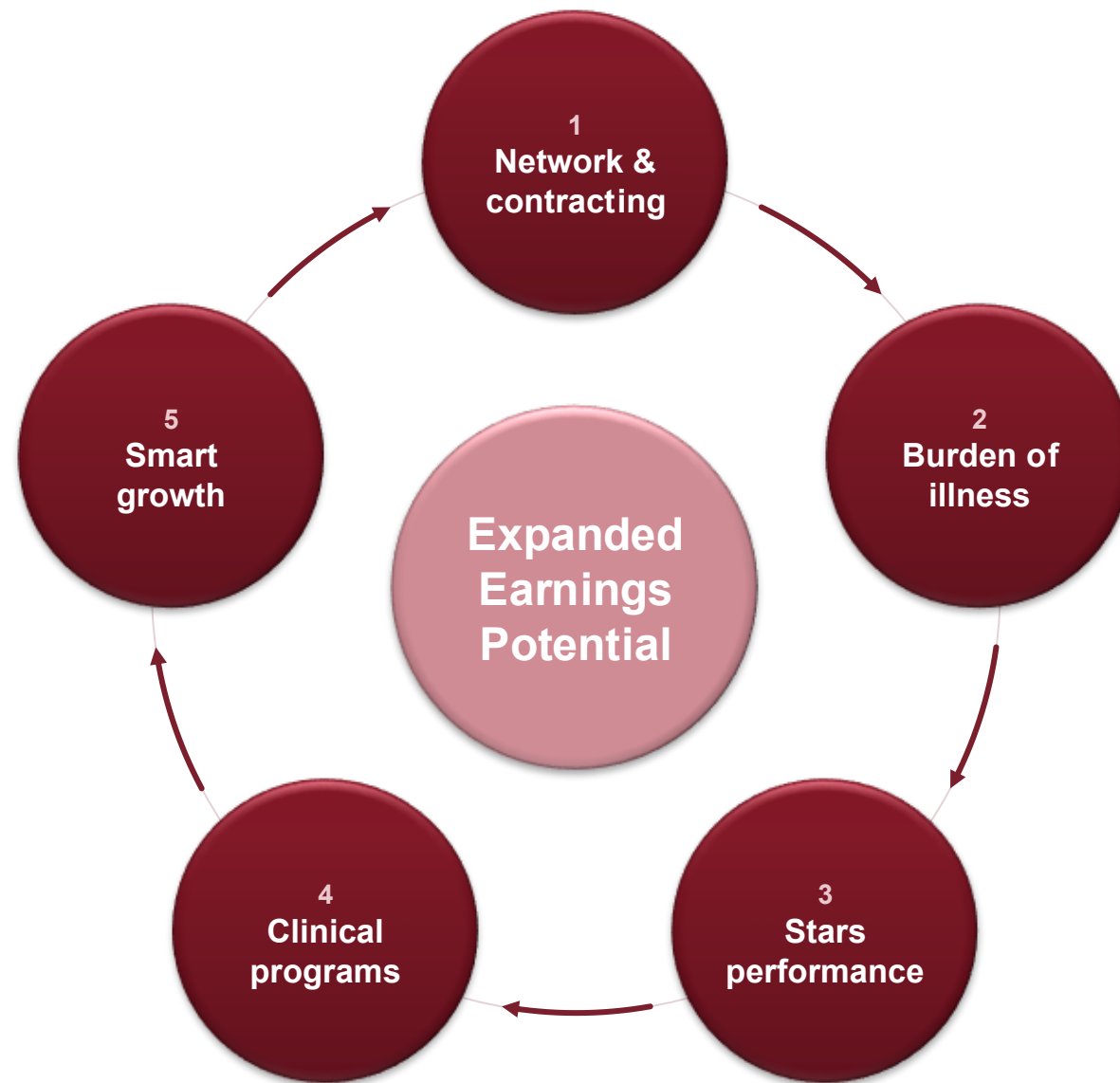
Five levers, each tied to a measured result and to a line of the P&L

	Lever	What we did	Proof	Moves
1	Contracts	Renegotiated payer terms; delegated functions for 63% of members	Per-member funding +15% YoY (2Q26)	Revenue
2	Documentation and quality	Point-of-care technology at the visit to close care gaps and document conditions accurately	65K+ lives; 90% of gaps closed; 87% of patients seen; 4 Stars at ~70% of priority plans	Revenue
3	Network	Concentrated members with Tier 1 PCPs; aligned incentives, surplus sharing, Restore coaching, specialty contracts	Tier 1 share ~56% to 62% of members	Medical cost
4	Clinical programs	Complex care, utilization management, transitions of care, high-cost drug management	99.5% of highest-risk members seen; 17% SNF-to-home redirect; cost trend 1.8% below 2025	Medical cost
5	Cost structure	Eliminated duplicative corporate infrastructure and vendor services	Operating expense \$112M to \$102M from 2024 to 2025	Other cost

Metrics from P3 1Q26 and 2Q26 earnings calls and 4Q25 release.

Unlocking Earnings Power: Value-Creation Levers

The levers reinforce each other: each turn of the wheel compounds earnings power



How each turn compounds

LEVER	RELATIVE SIZE	MATURITY ¹
1 Network & contracting Denser network & delegation		
2 Burden of illness Complete, accurate coding matches revenue to member acuity		
3 Stars performance Quality bonuses & revenue tier improvement		
4 Clinical programs Lower cost for sickest members		
5 Smart growth Margin funds new markets		

■ = relative scale of opportunity (management's internal assessment); not a financial estimate

Relative size and maturity reflect management's internal assessment and are illustrative only; not targets, projections or guidance. (1) Maturity: how established each lever is today; a fuller bar indicates a more mature, proven capability.

A Repeatable Growth Model: Partner, Prove, Then Take Risk

Reduces volatility, capital-light, and a repeatable blueprint: infrastructure is built and performance proven before P3 takes risk

WHERE: Market opportunity

63 plans

Mid-market MA plans (25K–300K members) similar to BCBS Nebraska

6M+ MA members

across those plans, with potential for a delegated-to-full-risk partnership

\$14–\$16B

mid-market MA revenue pool addressable through the outlined playbook

WHY WE WIN: P3 controls more of the levers

Lever	Traditional model	P3 model	Incremental impact
Bid & benefit design			} +5-10% plan economics improvement, depending on starting point
Claims			
Utilization management			
Care management			} +5-10% operational levers: claims, UM, care management, payment integrity
Payment integrity			
Quality			
Provider governance			
Staged risk-taking			

Partner controls Shared Payer retains

HOW: Three-phase glidepath

Phase 1 | Delegated operations

- Build clinical and operational infrastructure
- Delegated functions ahead of risk

Establish infrastructure

Phase 2 | Increase Scope of Services

- Claims processing and payment
- Benefit design and bid strategy; contractual performance metrics

Expanding delegation

Phase 3 | Full risk

- Full capitation economics
- Grow membership and product offerings

10x Current Mgmt. Services Revenue

Lever comparison and +5-10% impact are management's illustrative assessment versus precedent delegated-risk models; not targets, projections or guidance. Revenue at full risk is at current membership. Market sizing: CPF market analysis. Source: P3 4Q25-2Q26 earnings calls.

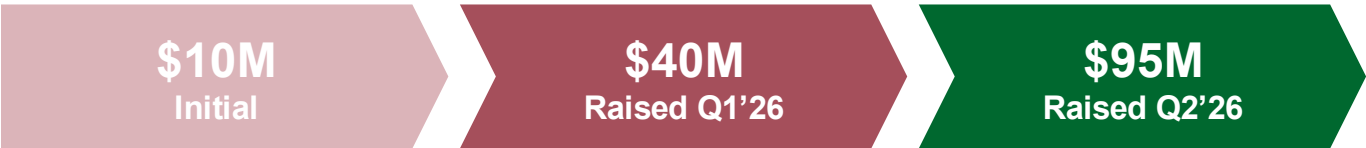
2026 Guidance and Earnings Quality

Guidance raised twice in 2026 to a \$95M midpoint; the core business is profitable before one-time items

2026 full-year guidance (as of August 2026)

Metric	Low	High
At-risk members	102,000	106,000
Total revenue (\$M)	\$1,500	\$1,600
Medical margin (\$M)	\$260	\$300
Medical margin PMPM	\$210	\$240
Adjusted EBITDA (\$M)	\$80	\$110

Adjusted EBITDA guidance midpoint



What is in the \$95M midpoint

	~\$62M settlements and prior year items (1H26)	~\$33M underlying
1H26 reported	~\$80M	= \$62M settlements/prior year + \$18M underlying
2H26 implied	~\$15M	underlying, at the guidance midpoint
FY26 midpoint	\$95M	= ~\$62M one-time items + ~\$33M underlying

About the settlements

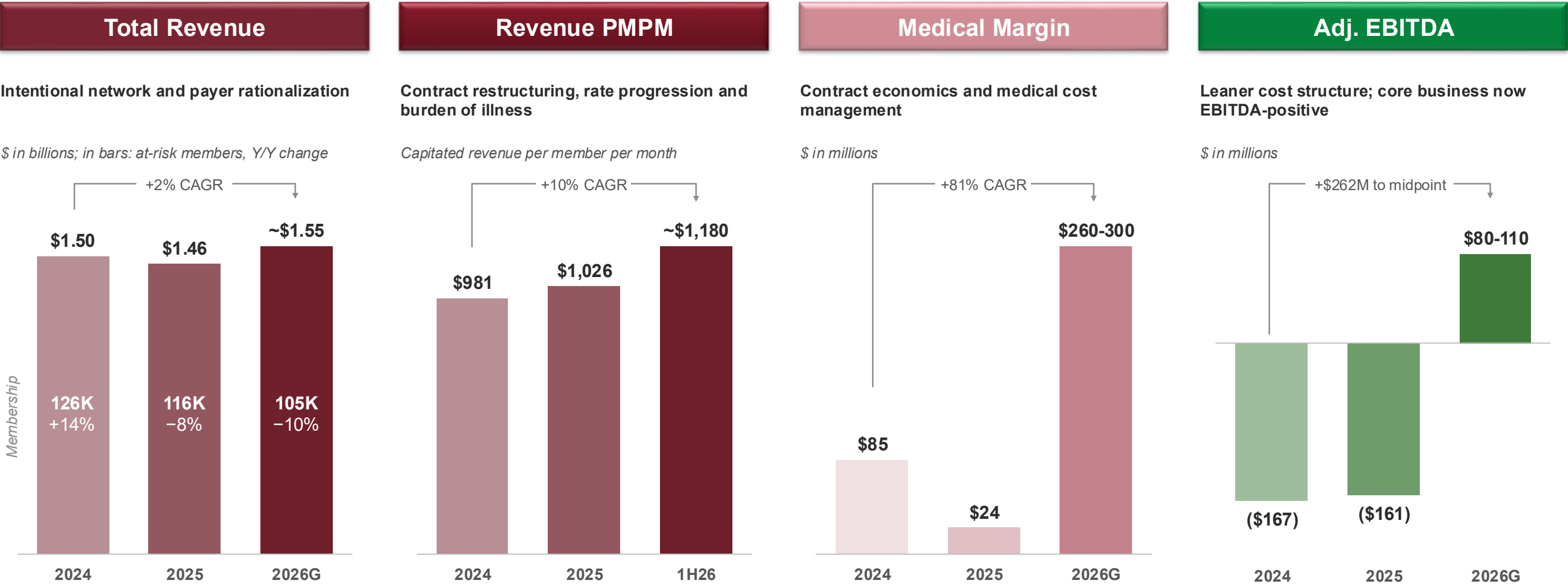
Constructive resolution of legacy contract matters with payer partners, recognized in 1H26. They reduced medical claims expense. Underlying results exclude them.

Drivers of 2026 improvement: contract restructuring and favorable CMS benchmark (revenue), medical cost management and network contracting (operations), benefit design and membership mix.

Underlying excludes payer settlements and prior year development; 1Q26 split approximate per 1Q26 call; 2H26 implied by guidance midpoint, not separately guided. Medical margin and Adjusted EBITDA are non-GAAP measures; see appendix.

The Turnaround in Numbers: Improvement Across Every Line

~\$262M Adjusted EBITDA improvement from 2024 to the 2026 guidance midpoint, with fewer, better-aligned members



2026G = full-year guidance as of 2Q26 (bar at midpoint, range labeled); includes \$62M of 1H26 payer settlements and prior year development. 1H26 revenue PMPM derived from 1H26 capitated revenue (\$745.9M) and member months implied by reported PMPM metrics. Medical margin and Adjusted EBITDA are non-GAAP measures; see appendix. Source: company earnings releases.

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Why P3: Three Takeaways

A turnaround delivered, meaningful embedded upside, and a repeatable model for smart growth

1

Turnaround delivered

Core business is EBITDA-positive. 2026 Adjusted EBITDA guidance of \$80-110M, raised twice, versus (\$161M) in 2025.

2

Embedded upside

Levers in the existing business drive earnings beyond 2026: burden of illness, Stars, clinical programs, and network and contracting.

3

Smart growth

A repeatable, capital-light model: delegated operations first, full risk once performance is proven. Proof point: Nebraska material revenue growth at full risk; 63 similar mid-market plans.

Questions and discussion

2026 guidance as of August 2026. RAF and Nebraska figures are illustrative and not guidance. Adjusted EBITDA is a non-GAAP measure; see appendix.

Appendix

Appendix: Reconciliation of Net Income (Loss) to Adjusted EBITDA

(\$ in thousands, except PMPM)

	1Q26	2Q26	1H26	1H25	FY2025
Net income (loss)	\$3,040	\$15,651	\$18,691	\$(87,911)	\$(323,086)
Interest expense, net	16,766	7,862	24,628	18,870	55,034
Depreciation and amortization	21,074	21,044	42,118	42,135	84,163
Income tax provision (benefit)	(10,997)	1,265	(9,732)	3,054	2,025
Mark-to-market of stock warrants and purchased put option (1)	(330)	16,366	16,036	(5,324)	(7,850)
Premium deficiency reserve	(4,715)	(8,659)	(13,374)	(12,929)	18,749
Equity-based compensation	1,051	866	1,917	3,271	5,581
Other (2)	(130)	50	(80)	(466)	4,108
Adjusted EBITDA (loss)	\$25,759	\$54,445	\$80,204	\$(39,300)	\$(161,276)
<i>Adjusted EBITDA (loss) PMPM</i>	<i>\$81</i>	<i>\$173</i>	<i>\$127</i>	<i>\$(87)</i>	<i>\$(116)</i>

Underlying Adjusted EBITDA (\$ in millions)

	1Q26	2Q26	1H26
Adjusted EBITDA	\$25.8	\$54.4	\$80.2
Less: payer settlements and prior year development (3)	(~17.0)	(45.2)	(~62.2)
Underlying Adjusted EBITDA	~\$8.8	\$9.2	~\$18.0

(1) Purchased put option included beginning 2Q26; prior periods reflect stock warrants only. (2) 2026: interest income partially offset by valuation allowance on notes receivable; 1H25: interest income partially offset by severance related to workforce reorganization; FY2025: see 4Q25 earnings release. (3) 1Q26 amount approximate, as disclosed on the 1Q26 earnings call. 1Q26 and 1H25 derived from company earnings releases. A reconciliation of forward-looking 2026 Adjusted EBITDA guidance to net income (loss) is not provided because certain reconciling items cannot be predicted without unreasonable effort.

Appendix: Reconciliation of Gross Profit (Loss) to Medical Margin

(\$ in thousands, except PMPM)

	1Q26	2Q26	1H26	1H25	FY2025
Gross profit (loss)	\$50,366	\$86,004	\$136,370	\$5,620	\$(60,160)
Other revenue (1)	(6,891)	(19,983)	(26,874)	(7,772)	(30,101)
Other medical expense	30,182	31,782	61,964	49,967	113,789
Medical margin	\$73,657	\$97,803	\$171,460	\$47,815	\$23,528

Medical margin (\$ in thousands, except PMPM)

	1Q26	2Q26	1H26	1H25	FY2025
Capitated revenue	\$379,499	\$366,398	\$745,897	\$721,241	\$1,428,979
Less: medical claims expense	(305,842)	(268,595)	(574,437)	(673,426)	(1,405,451)
Medical margin	\$73,657	\$97,803	\$171,460	\$47,815	\$23,528
Medical margin PMPM	\$231	\$311	\$271	\$69	\$17

Excluding payer settlements and prior year development, 2Q26 medical margin was \$52.9 million, or \$168 PMPM.

Medical margin is a non-GAAP measure defined as capitated revenue less medical claims expense. (1) Presented as "other patient service revenue" in FY2025 reporting. 1Q26 gross profit reconciliation derived as 1H26 less 2Q26. Source: company earnings releases.