



People. Passion. Purpose.

**Investor Presentation**  
**May 2026**



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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, 2023, filed with the SEC on March 28, 2024, 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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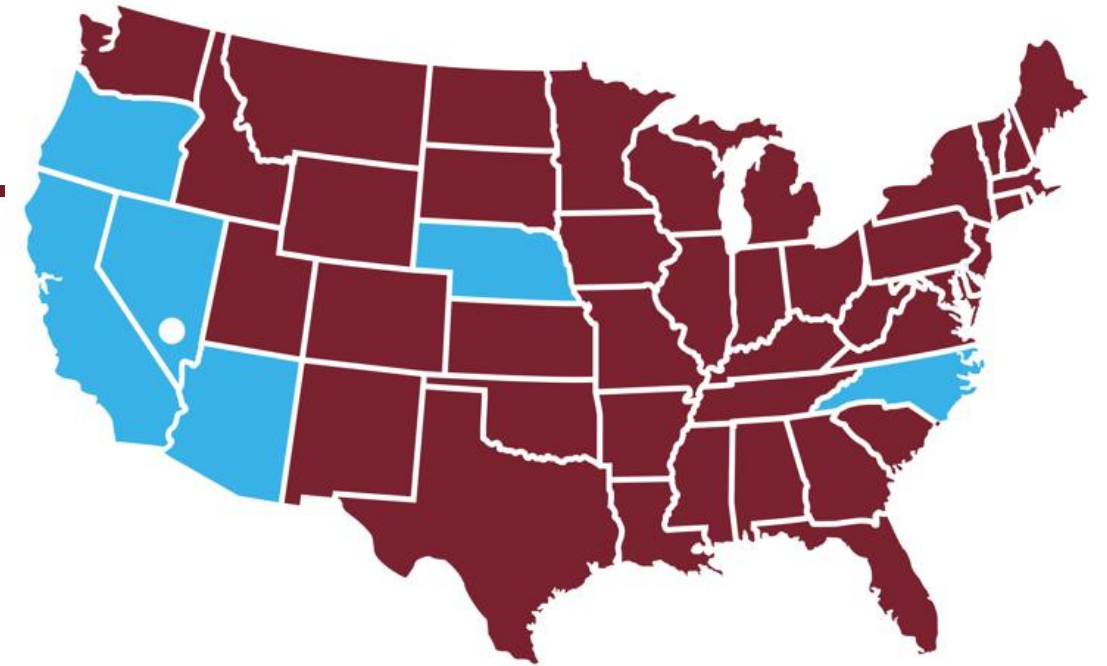
## P3 Health Partners at a Glance

**P3 Health Partners** is a physician enablement organization that takes global risk in a rapidly growing \$1.2T Medicare Advantage and FFS Medicare market.

A **physician led organization**, enabling physicians, care teams and practices on their journey from traditional fee-for-service to value-based care.

Creating **enhanced patient outcomes** and experiences, greater professional satisfaction for providers and caregivers, and lower care costs.

Leveraging a deeply-integrated and **capital efficient care model**, data and technology, physician leadership, and community outreach tools.



**135K**

**Total Lives**

*~106K At-Risk Lives*

*~29K Lives Under Management*



**6 States**

*Nebraska & North Carolina new in 2026*



**2,400+**

**Primary Care Providers**

*PCPs in Full-Risk Network*



**17**

**Payor Partners**

## Our Mission is to be the Best Health Partner for: Patients, Providers, & Payers



**Large and durable market with compelling margin potential**  
Full-risk Medicare Advantage rewards scaled operators who can manage total cost of care



**Structural improvement driving profitability**  
Stronger contract economics, disciplined cost management, and improved provider alignment create a clear and near-term path to positive EBITDA



**Fully delegated risk model**  
Leveraging data, AI-enabled insights, and technology to deliver better clinical outcomes at lower costs



**Scaled networks of deeply-integrated and capital efficient care models** into highly attractive geographic markets



**Experienced leadership team** across executive and physician leadership with a track record of executing in value-based care



# Core Market Execution: The Economic Engine

The operational work completed in P3's core markets is already embedded in the business and driving measurable financial improvement

## FOUNDATIONAL IMPROVEMENTS

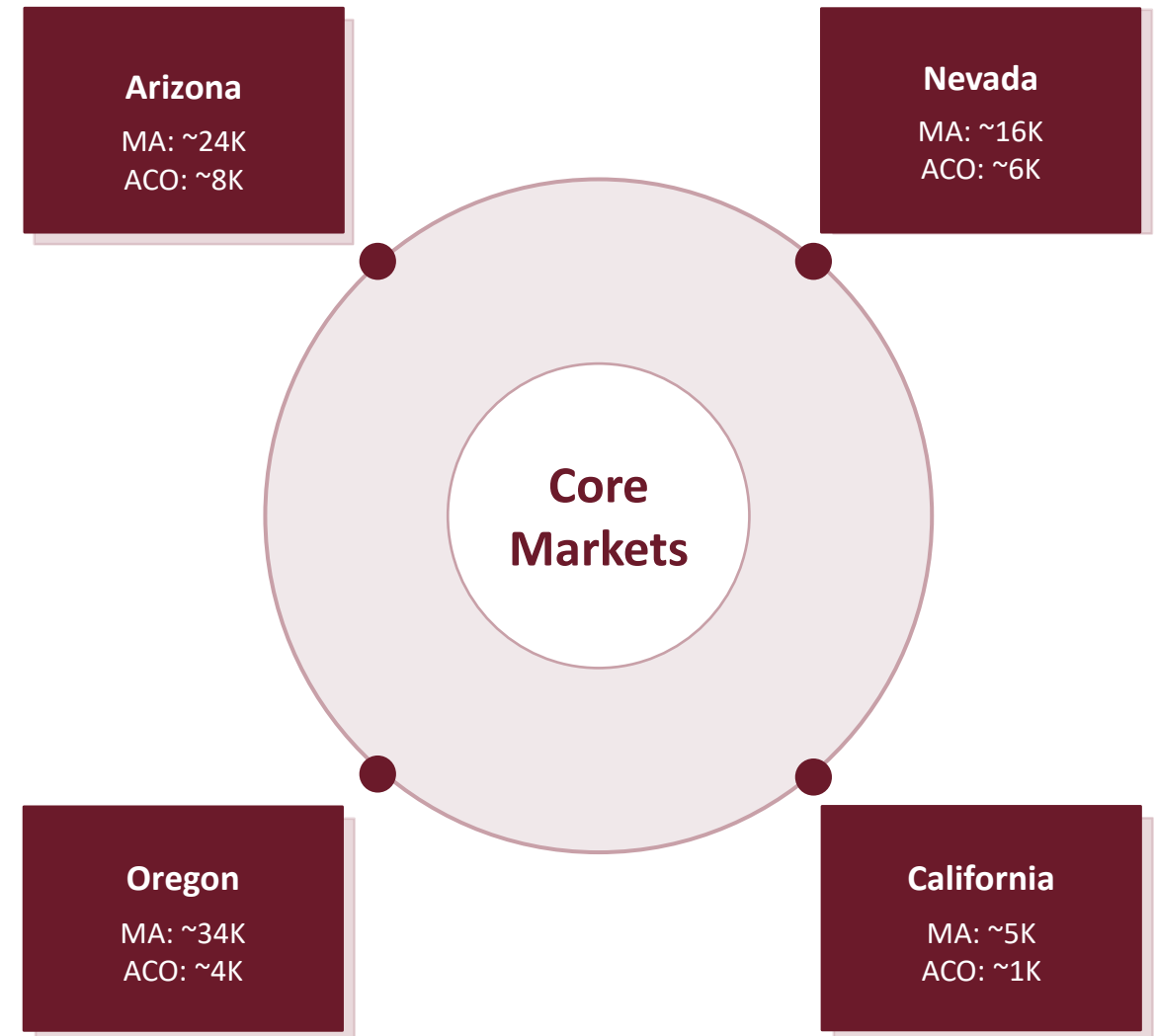
The operating expense and contract work completed in 2025 is embedded in the business entering 2026. Renegotiated payer arrangements, a leaner operating structure, and improved provider accountability have reset the financial baseline.

## STARS & QUALITY PERFORMANCE

Star rating performance strengthens payer engagement and signals execution credibility to partners. P3's quality trajectory entering 2026 reinforces the value proposition across existing payer relationships and supports favorable terms in new arrangements.

## RUNWAY IN EXISTING MARKETS

P3's existing markets contain significant untapped density within current TINs. Growing attribution within proven, high-performing provider relationships is the highest-return, lowest-risk path to margin improvement.



# Expansion into New Markets and Smart Growth

## New MA Geography: Nebraska

- ❖ Partnership expands P3 into a new Medicare Advantage geography, adding 29K members under management
- ❖ Includes delegated functions from day one, ahead of full risk assumption, with a structured multi-year glidepath to full capitation

## GLIDEPATH TO FULL RISK

Phase 1 2026	Phase 2 2027	Phase 3 2028+
<p><i>Delegated Operations</i></p> <ul style="list-style-type: none"> <li>• Establish clinical &amp; operational infrastructure</li> <li>• Take on delegated functions prior to full risk</li> <li>• Performance monitoring and data integration</li> <li>• ~\$30M revenue contribution</li> </ul>	<p><i>Expanding Delegation</i></p> <ul style="list-style-type: none"> <li>• Assume delegation for claims processing and payment</li> <li>• Deepen clinical integration</li> <li>• Demonstrate quality metrics and cost management</li> <li>• Partner on benefit design and bid strategy</li> </ul>	<p><i>Full Risk</i></p> <ul style="list-style-type: none"> <li>• \$300M+ revenue at current membership levels</li> <li>• Full capitation economics realized</li> <li>• Proven execution foundation in place</li> <li>• Long-term earnings power unlocked</li> <li>• Grow membership and product offerings</li> </ul>

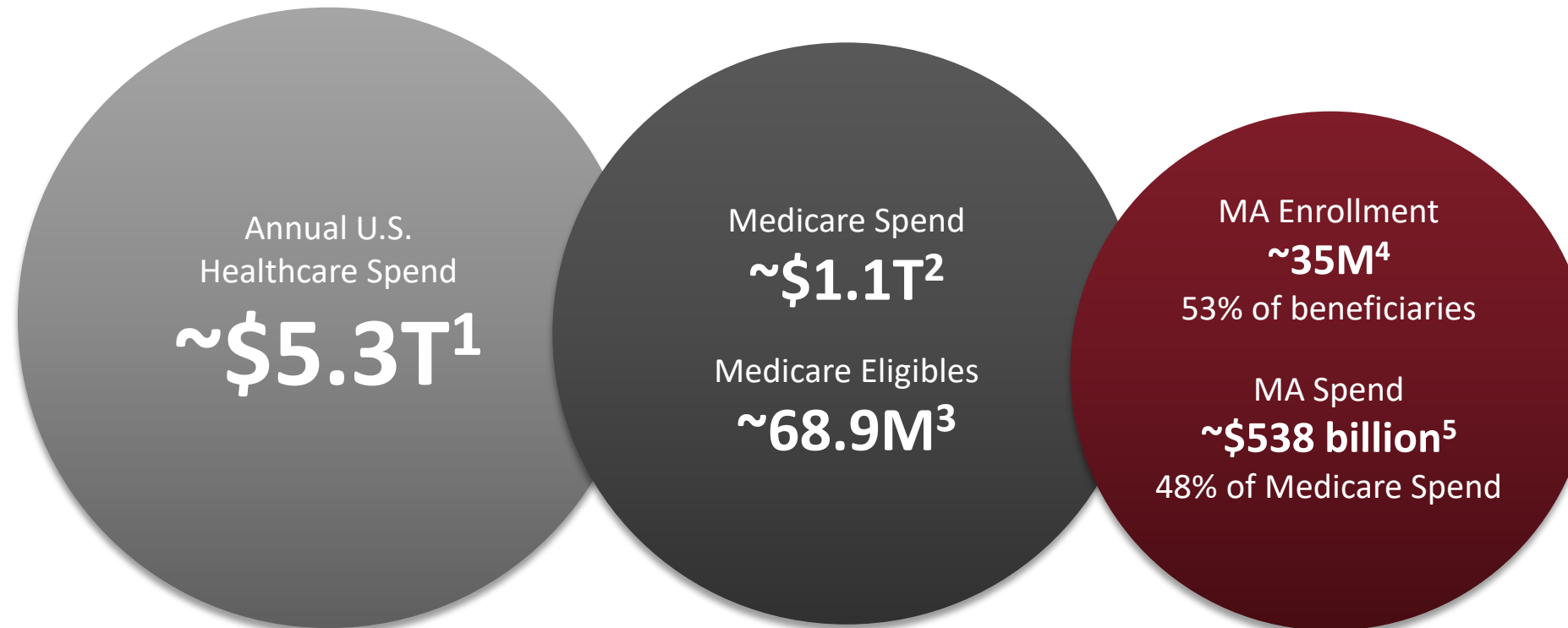
## Glidepath to Full Risk

P3 enters Nebraska through a structured, multi-year glidepath, building operational infrastructure before assuming full capitation risk.

## Repeatable and Scalable

This model becomes P3's blueprint for new market entry; a proven, low-volatility pathway to full risk that can be deployed in future markets.

# P3 is Addressing a Substantial Market Opportunity



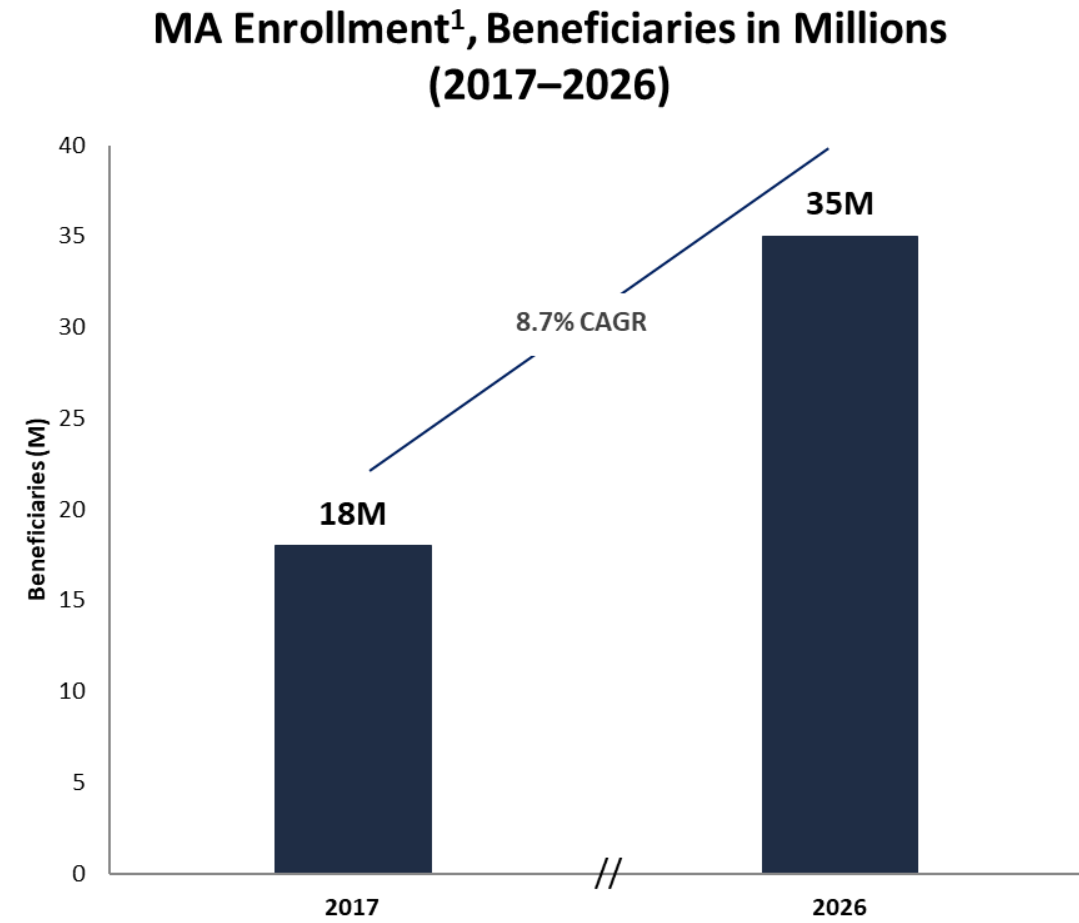
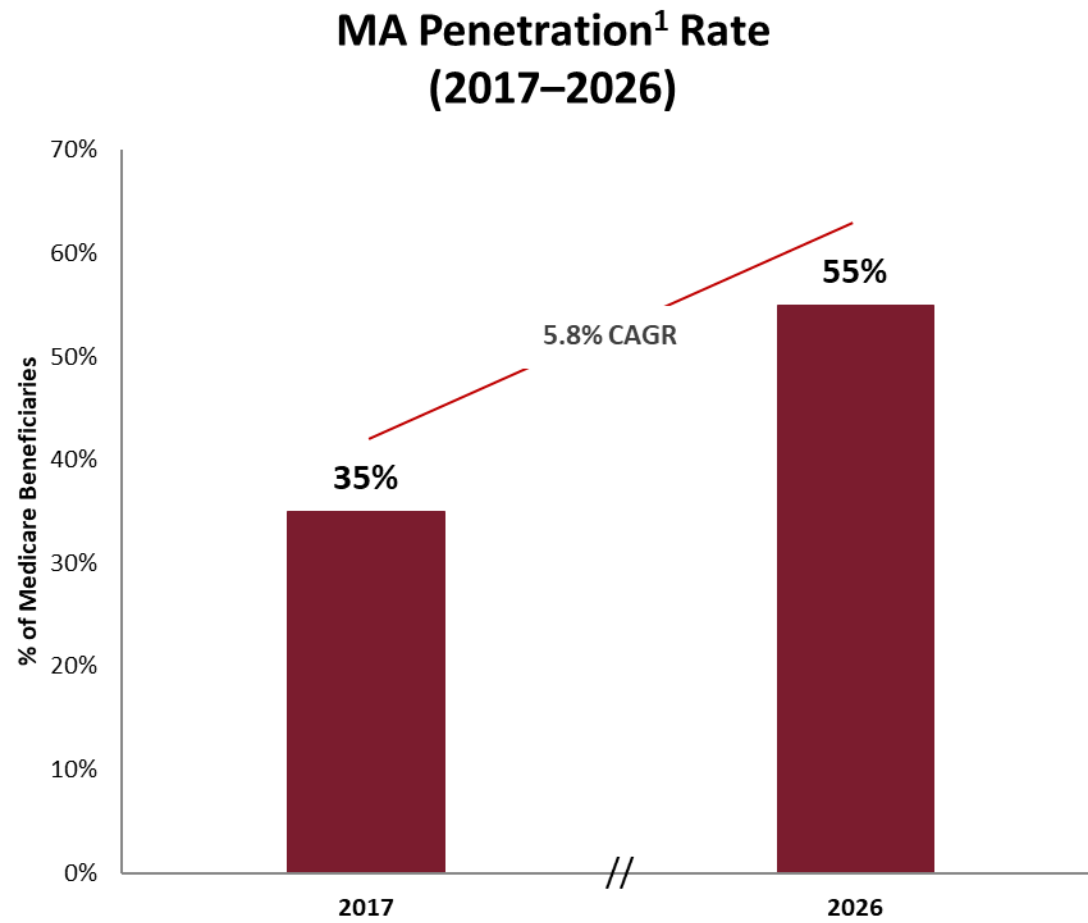
## Industry Shifts Driving Opportunity for P3



Footnotes: 1) CMS.gov 2024 2) 2024 KKF 3) CMS.gov May 2025 4) Kff.org 2025 5) MedPAC report to congress, March 2025

# Medicare Advantage Is Now the Majority of Medicare

55% penetration and 35M beneficiaries reflects a structural shift that defines P3's market opportunity



Footnotes: 1) KKF: Medicare Advantage in 2025: Enrollment Update and Key Trends. Total Medicare denominator represents Part B Enrollees eligible for MA.

# Value-Based Care is Bending the Medical Cost Curve and Is Here to Stay

Medicare spending **in total** has increased dramatically as more beneficiaries age in,

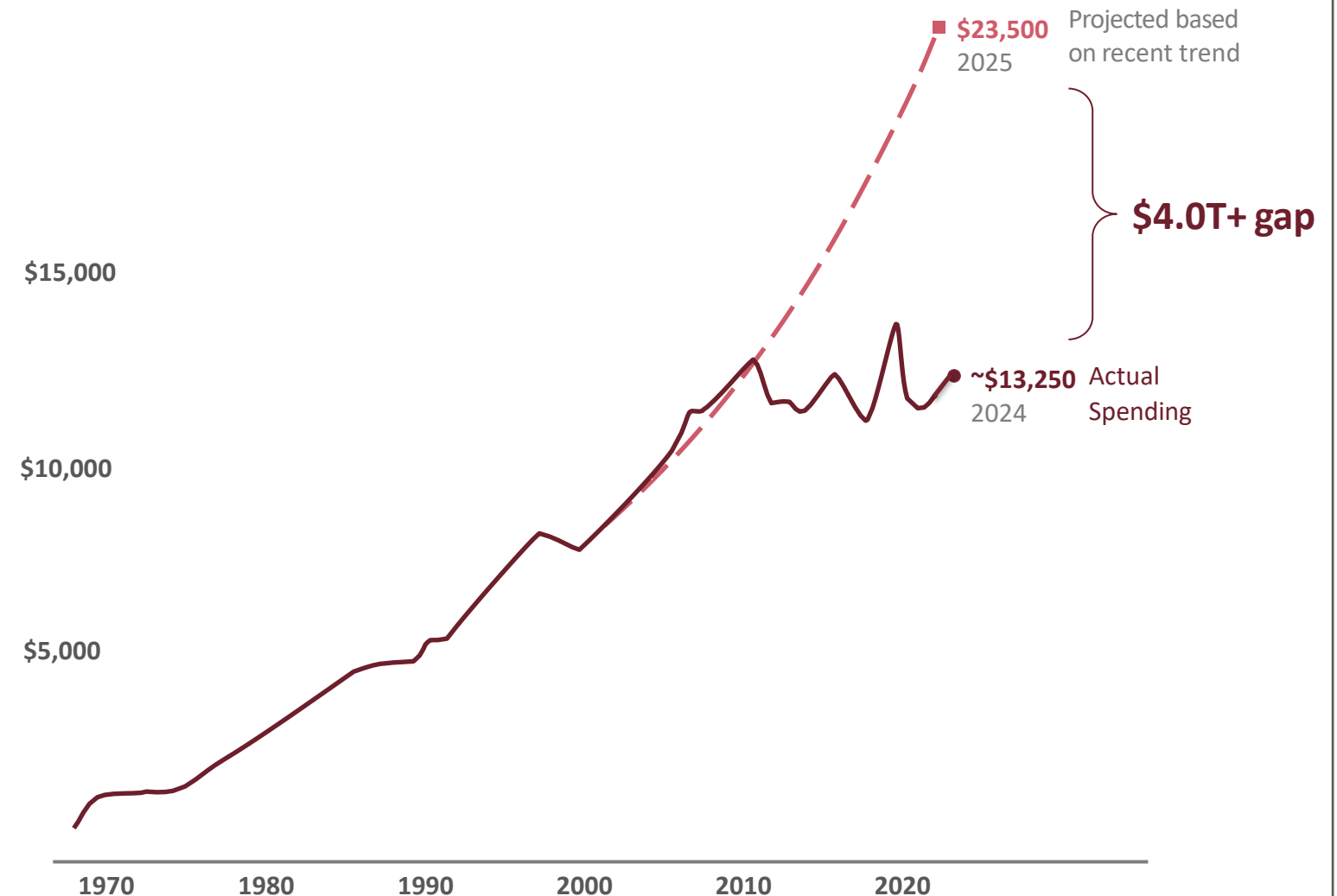
however

**Per beneficiary spending has been meaningfully below historical projected trend since 2012**

amounting to a

**\$4.0+ trillion spending gap** from the projected trend, highlighting value-based care's contribution in bending the cost curve.

### Annual Medicare Spending Per Beneficiary <sup>1</sup>



Footnote 1: CMS National Health Expenditure Data; MedPAC (2025 Data Book); Congressional Budget Office (historical projections)

# Value-Based Care Payment Model

## Status Quo: FEE FOR SERVICE

Under a **fee for service (FFS)** payment model, physicians are reimbursed based on the **quantity of patients treated, regardless of the quality outcome.**

Uncontrolled  
High Costs

**\$1.1T**

*US spending on Medicare (2024)<sup>1</sup>*

Poor Quality of Care and  
Clinical Outcomes

**42%**<sup>3</sup>

of Americans have 2+ chronic  
conditions

Inadequate Access to Primary  
Care

**~33%**<sup>4</sup>

Americans do not have access to  
essential primary care

Physician  
Burnout

**~50%**<sup>5</sup>

of PCPs show signs of burnout and  
report feeling unfairly compensated

## P3 Health Partners: VALUE-BASED CARE

Physicians are reimbursed based on the **quality of care** rather than the **quantity of services provided.**

**REDUCED  
COSTS**

~10% savings in medical  
spending within first ~5+  
years of VBC  
implementation<sup>2</sup>

**ENHANCED QUALITY  
WITH BETTER CLINICAL  
OUTCOMES**

Realigning physician  
incentives to prioritize overall  
health of patient and promote  
preventative care

**INCREASED ACCESS  
TO PRIMARY CARE**

VBC reimbursement model  
reflects additional payment  
for improved access to care

**LOWER PHYSICIAN  
BURNOUT**

PCPs spend more time with  
each patient promoting  
more sustainable workplace  
behaviors

# P3's Value-Based Platform Drives Consistent Results

Streamlining operations so physicians can prioritize patient relationships

## PROVIDER ENGAGEMENT

- Reducing performance variability and creating alignment of incentives with quality outcomes
- Referral insights

## TARGETED CLINICAL INTERVENTIONS

- Expanded access through enhanced network management and care coordination
- Personalized care plans including care gap identification, virtual assistant, in-home visit scheduling, medication management

## DATA & ANALYTICS

- Advanced portal that streamlines prior authorizations and claims reviews
- Data driven model to drive optimal care pathways

Platform unifies, aggregates, and normalizes clinical and claims data across health plans, EHRs, HCIT systems, and community sources

Optimized Risk Stratification

Comprehensive Utilization Management

Tailored Care Management

Empowered Collaboration

# The Four Operational Pillars of P3's Playbook



## **Patient Outcomes** *Population Targeting & Outcome Measurement*

- Risk stratification and targeted interventions by population
- Measurable ROI driven by care outcomes
- Closing care gaps and achieving 4 Stars+ in quality performance



## **Reduce Cost and Improved Efficiency** *Tech-Enabled Clinical Operations*

- AI and predictive analytics surfacing actionable insights at the point of care
- Revamped tools, training, and processes driving back-office efficiency
- Flexible integration to meet partners where they are on systems and data, while scaling enterprise capabilities



## **Patient and Care Team Well-being** *Enabling Providers*

- Reduce administrative burden and improve workflows
- Shift from volume-based practice to value-based practice
- Provide the tools, education, and coaching needed to be successful and reduce burnout



## **Scale Drives Performance** *Measurable Value Creation*

- Increase membership in each practice of existing market
- Contract optimization focused on sustainable margin improvement
- Expand partnerships within each market to increase overall density through MA and ACO populations

# Building the Path to Value-Based Excellence

## Building the Foundation

*Early Momentum, Lasting Results*

1

- Build physician relationships, get feedback
- Identify and prioritize specialty/network opportunities
- Focus on High-Cost Drug Management
- Revamp Prior Authorization & Concurrent Review

## Empowering the Network

*Unlock network potential for measurable outcomes*

2

- Align physician incentives and create contractual relationship
- Establish EMR connectivity with practices
- Execute on specialty and network opportunities
- Launch TOC & Chronic Care Programs

## Optimize Performance

*Strengthening the PCPs Performance*

3

- Plan and implement Practice support services and clinical programs
- Establish performance reviews and real-time interventions
- Coaching for results and impact
- Influence referral patterns to higher quality – lower cost specialists and facilities

## Full Risk Transition

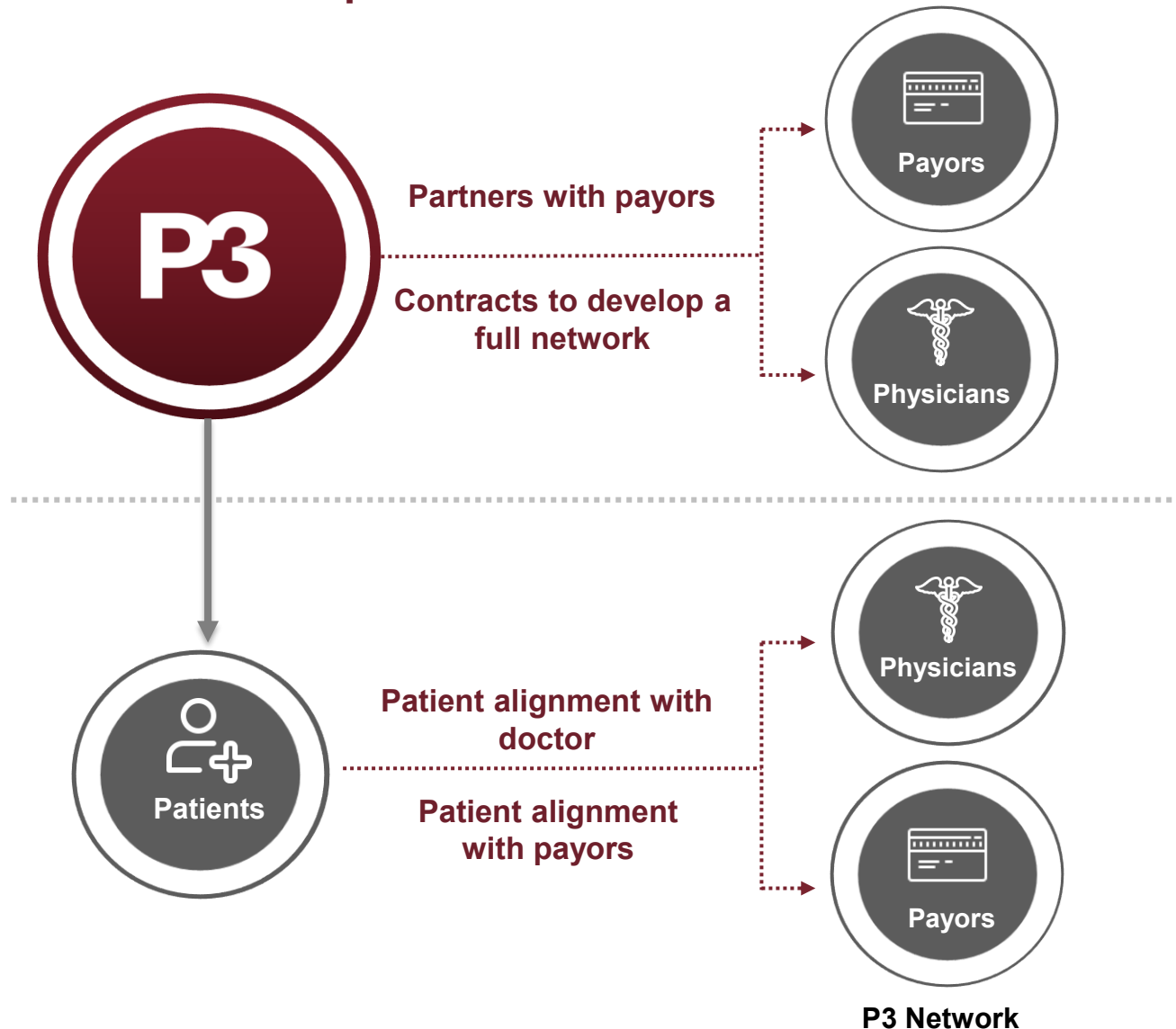
*Glide Path to Risk*

4

- Transition to risk
- Curate network
- PCP surplus sharing
- Age-in and AEP provider-based growth strategy

# P3 Integrated Patient Journey Results in Coordinated Care Delivery

P3 coordinates care with lower costs and improved patient health outcomes.



P3 navigates, coordinates, and integrates care to create a customized care plan for each patient.

## P3 Assumes Financial Risk

Through its contract with the MA plan, P3 assumes the full financial risk for the patient, officially making them a “P3 Member.”

## Coordinated Care Delivery

Patient receives coordinated care focused on prevention and wellness, managed by their PCP and supported by P3’s resources.

## Status Quo Patient Journey

1. *Unconnected choices* – the plan and PCP are not connected by a shared risk model
2. *Misaligned Incentives* – health plan’s goal (manage cost) and provider incentive (more services) are at odds creating inefficiency
3. *Reactive, Episodic Care* – care is delivered and paid for on fee-for-service basis

# Business Trajectory & Key Milestones

Structural work completed 2024–2025 drives toward profitability 2026

2023	2024	2025	2026
<p><b>The Starting Point</b></p> <ul style="list-style-type: none"> <li>• Unfavorable contract economics across key payer relationships</li> <li>• Provider network lacking accountability and value-based alignment</li> </ul>	<p><b>New Leadership Team</b></p> <ul style="list-style-type: none"> <li>• CEO and CFO transitions completed (Q2 and Q3 2024, respectively)</li> <li>• Contract restructuring and strategic reset initiated</li> </ul>	<p><b>Operational Efficiencies</b></p> <ul style="list-style-type: none"> <li>• Eliminated duplicative corporate infrastructure</li> <li>• Investment in key talent across Legal, Contracting, and Finance</li> <li>• Contract restructuring of key payer relationships</li> </ul>	<p><b>Contracts Inflecting</b></p> <ul style="list-style-type: none"> <li>• \$125M revenue &amp; contracting improvement embedded</li> <li>• New MA geography adds ~30k lives with positive cash flow and EBIDTA</li> </ul>
<p><b>Baseline Conditions</b></p> <ul style="list-style-type: none"> <li>• Limited visibility into utilization and claims performance</li> <li>• Operational infrastructure not scaled for value-based risk</li> </ul>	<p><b>Network Realignment</b></p> <ul style="list-style-type: none"> <li>• Provider network concentrated toward Tier 1 provider groups</li> <li>• Care Enablement Model deployed</li> </ul>	<p><b>Quality &amp; Star Performance</b></p> <ul style="list-style-type: none"> <li>• 4-Star status across ~70% of priority MA plans</li> <li>• Tier 1 network expanded to 50%+ of members</li> <li>• Complex Care program scaled</li> </ul>	<p><b>Path to Profitability</b></p> <ul style="list-style-type: none"> <li>• <b>Revised Adjusted EBITDA Guidance: \$20M to \$60M</b></li> </ul>

## Revised 2026 Guidance: Raises Midpoint to \$40M Adjusted EBITDA

2026 Guidance range of \$20M to \$60M reflects impact of underlying performance, as well as prior-year development and payer settlements recognized in the first quarter.

Revised: 2026 Full-year Guidance		
Metric	Low	High
At-Risk Members	103,000	110,000
Total Revenues (in millions)	\$1,500	\$1,650
Medical Margin (in millions)	\$190	\$230
Medical Margin PMPM	\$149	\$180
<b>Adjusted EBITDA (in millions)</b>	<b>\$20</b>	<b>\$60</b>

### Drivers of year-over-year performance:

Revenue & Contracting	Operational Execution	Payer & Mix
Contract restructuring, bid optimization, favorable CMS benchmark	Medical cost management and network contracting	Benefit design and membership mix changes

# P3 OPPORTUNITY: NEW LEADERSHIP TEAM IN PLACE FROM HEALTHCARE PARTNERS & OPTUM



**Aric Coffman, MD**  
Chief Executive Officer

**~20 Years of Experience**

Honest Medical Group:  
Grew revenue from zero to \$1.3BN from 2021 to 2024, raising \$150M+ in equity capital

Everett Clinic: Grew revenue from \$650M to \$1.15BN and Operating Income from (\$10M) to \$38M from 2017 to 2020



**Leif Pedersen**  
Chief Financial Officer

**~25 Years of Experience**

CFO of shared services across large national value-based care enterprise

Responsible for driving operational improvements while driving cost effective outcomes



**Amir Bacchus, MD**  
Co-Founder & Chief Medical Officer

**~30 Years of Experience**

Responsible for HCP Nevada market with ~\$125M of EBITDA, 52 clinics, 200 employed clinicians, and 1,400 affiliates

Successfully bent the cost curve in HCP Nevada, decreasing medical costs by 12%+



**Bill Betterman**  
Chief Operating Officer

**~25 Years of Experience**

Optum: Accountable for \$1B+ P&L for the Pacific Northwest Region, growing from 600 clinicians to over 1,100

Aurora Healthcare: COO of Aurora Medical Group, grew the practice to ~\$1.2B in operating revenue



**Todd Smith**  
Chief Legal and Compliance Officer

**~25 Years of Experience**

Optum: Supported growth from 3 to 75 markets through M&A, delegated risk models, and regulatory strategy

Elevance Health: General Counsel oversaw legal teams across business units and co-led the launch of Mosaic Health in 2024



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# Questions?