



People. Passion. Purpose.

**Investor Presentation
August 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.

Industry and Market Data

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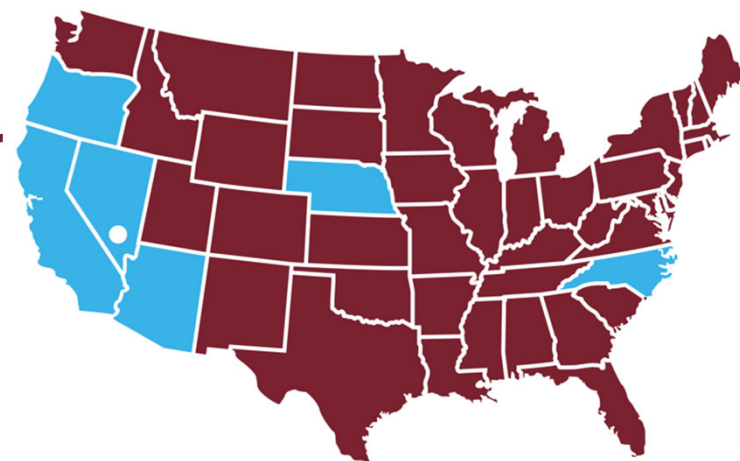
P3 Health Partners at a Glance

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

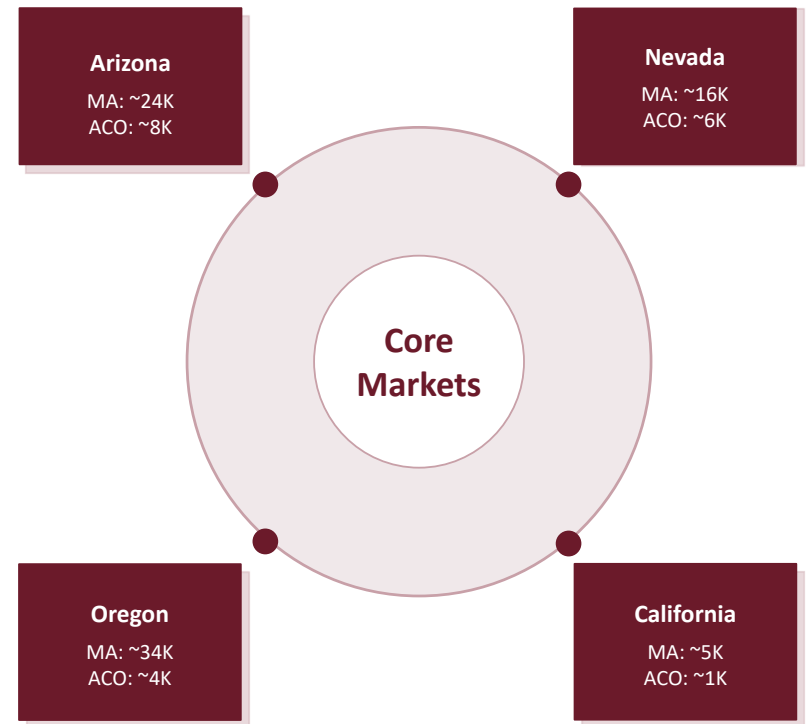
The operating expense and contract work completed in 2025 is embedded in the business entering 2026. Renegotiated payer arrangements, a leaner operating structure, and improved provider accountability have reset the financial baseline.

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

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

Repeatable and Scalable

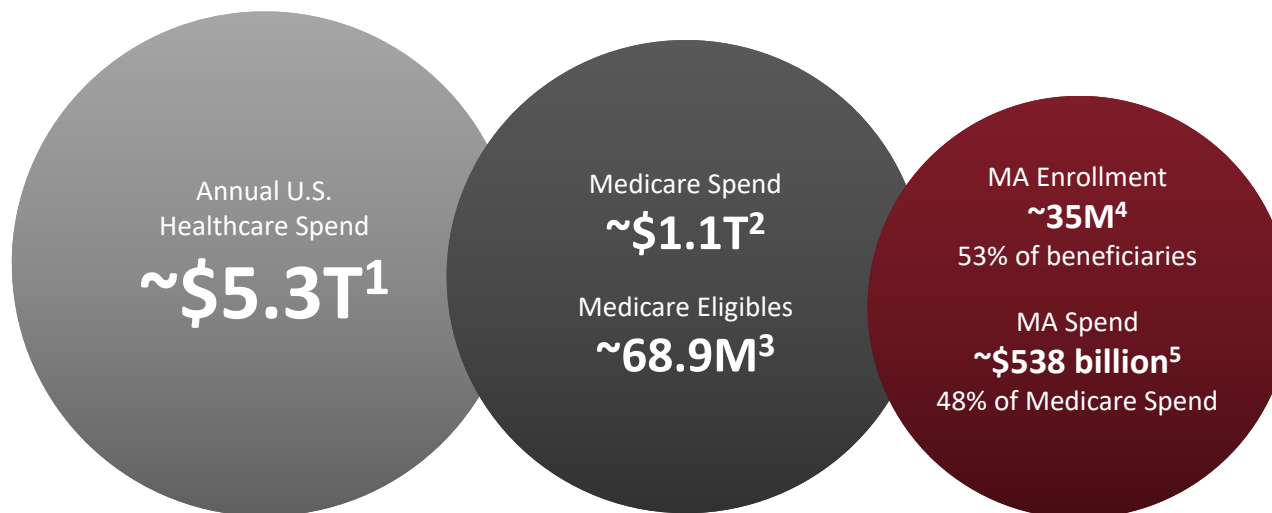
This model becomes P3's blueprint for new market entry; a proven, low-volatility pathway to full risk that can be deployed in future markets.

GLIDEPATH TO FULL RISK

Phase 1 2026	Phase 2 2027	Phase 3 2028+
<i>Delegated Operations</i>	<i>Expanding Delegation</i>	<i>Full Risk</i>
• Establish clinical & operational infrastructure • Take on delegated functions prior to full risk • Performance monitoring and data integration • ~\$30M revenue contribution	• Assume delegation for claims processing and payment • Deepen clinical integration • Demonstrate quality metrics and cost management • Partner on benefit design and bid strategy	• \$300M+ revenue at current membership levels • Full capitation economics realized • Proven execution foundation in place • Long-term earnings power unlocked • Grow membership and product offerings

Reduces volatility · Builds operational foundation ahead of risk · Creates structured pathway to long-term earnings power

P3 is Addressing a Substantial Market Opportunity



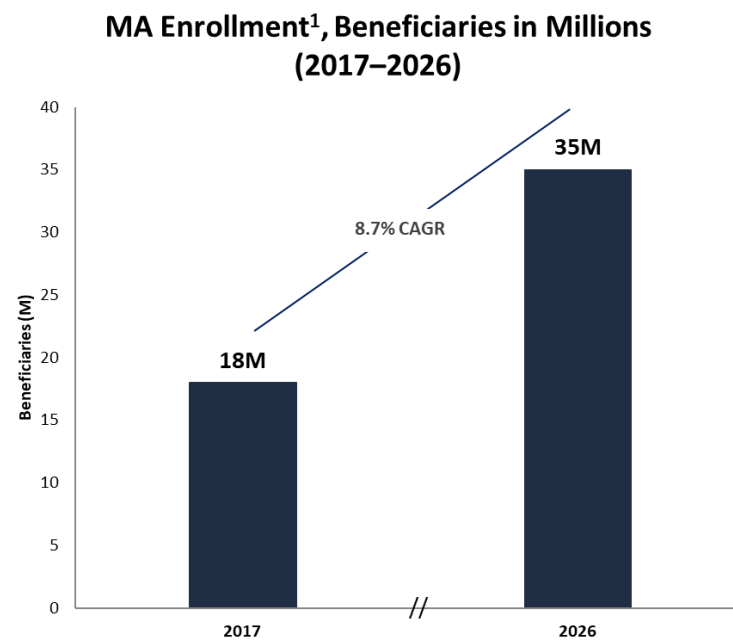
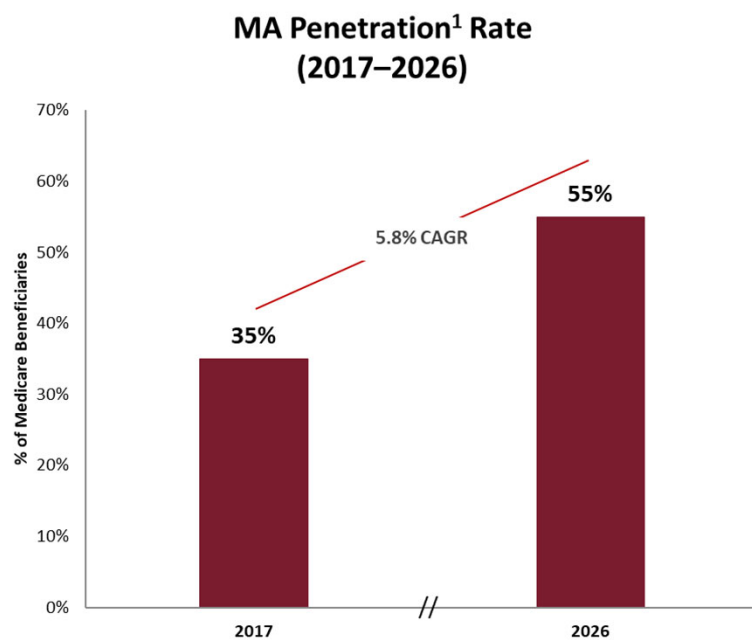
Industry Shifts Driving Opportunity for P3



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

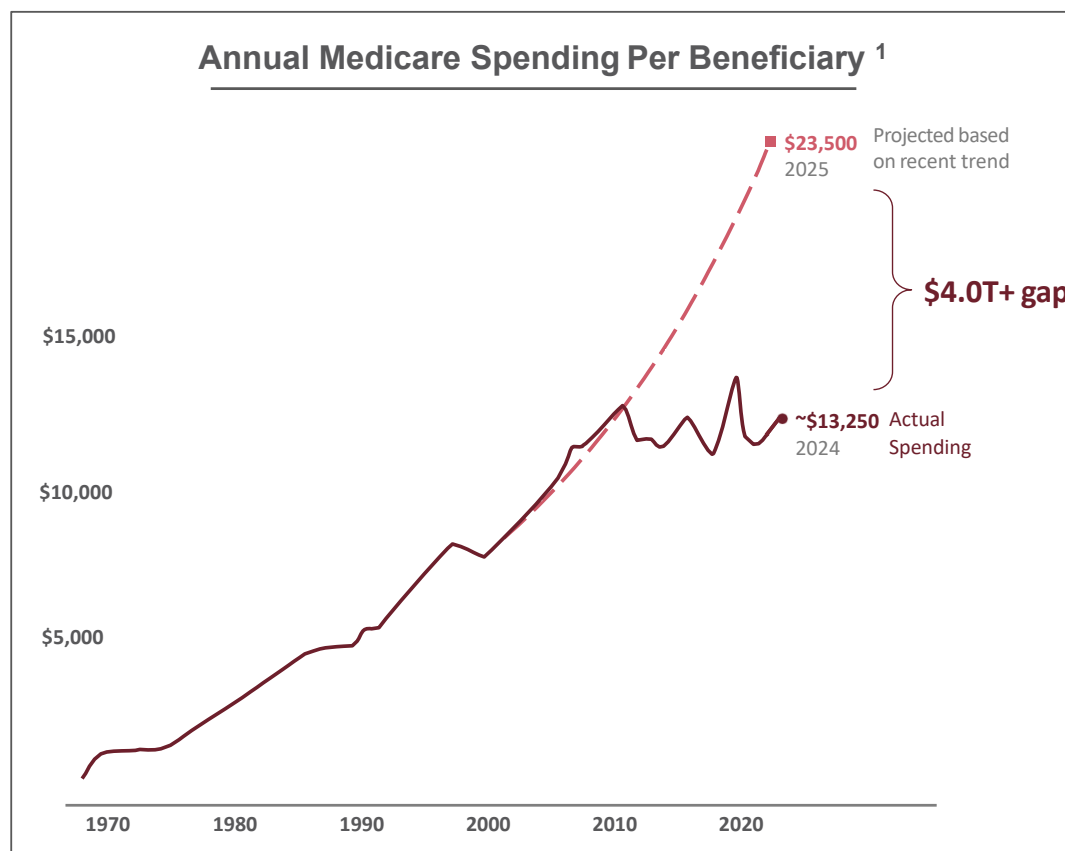
Medicare spending **in total** has increased dramatically as more beneficiaries age in,

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.



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)¹

Poor Quality of Care and
Clinical Outcomes

42%³

of Americans have 2+ chronic
conditions

Inadequate Access to Primary
Care

~33%⁴

Americans do not have access to
essential primary care

Physician
Burnout

~50%⁵

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
implementation²

**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

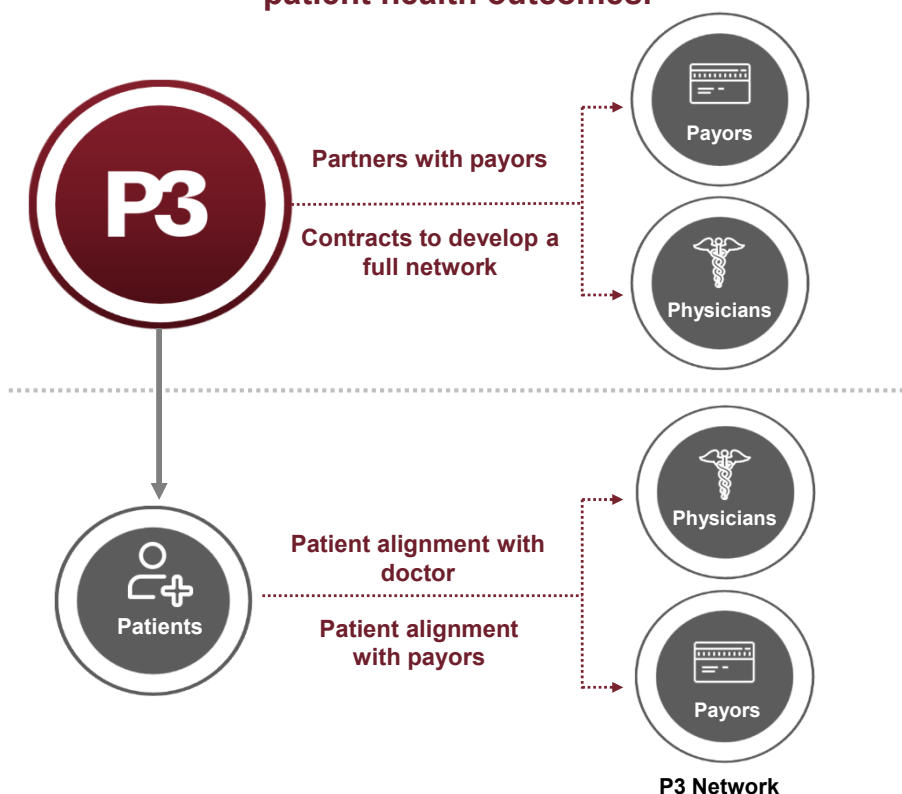
Glide Path to Risk

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
The Starting Point - Unfavorable contract economics across key payer relationships - Provider network lacking accountability and value-based alignment	New Leadership Team - CEO and CFO transitions completed (Q2 and Q3 2024, respectively) - Contract restructuring and strategic reset initiated	Operational Efficiencies - Eliminated duplicative corporate infrastructure - Investment in key talent across Legal, Contracting, and Finance - Contract restructuring of key payer relationships	Contracts Inflecting \$125M revenue & contracting improvement embedded - New MA geography adds ~30k lives with positive cash flow and EBIDTA
Baseline Conditions - Limited visibility into utilization and claims performance - Operational infrastructure not scaled for value-based risk	Network Realignment - Provider network concentrated toward Tier 1 provider groups - Care Enablement Model deployed	Quality & Star Performance 4-Star status across ~70% of priority MA plans - Tier 1 network expanded to 50%+ of members - Complex Care program scaled	Path to Profitability Revised Adjusted EBITDA Guidance: \$80M to \$110M

Revised 2026 Guidance: Raises Midpoint to \$95M Adjusted EBITDA

2026 Guidance range of \$80M to \$110M reflects impact of underlying performance, as well as prior-year development and payer settlements recognized in the first half.

Revised: 2026 Full-year Guidance		
Metric	Low	High
At-Risk Members	102,000	106,000
Total Revenues (in millions)	\$1,500	\$1,600
Medical Margin (in millions)	\$260	\$300
Medical Margin PMPM	\$210	\$240
Adjusted EBITDA (in millions)	\$80	\$110

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

honest

Davita
Medical Group

The Everett Clinic
Part of Optum®

Optum

Davita
Medical Group

HealthCare Partners
Nevada

 PINNACLE



Elevance
Health

Questions?