P3 Health Partners

People. Passion. Purpose.

Investor Presentation
April 2026

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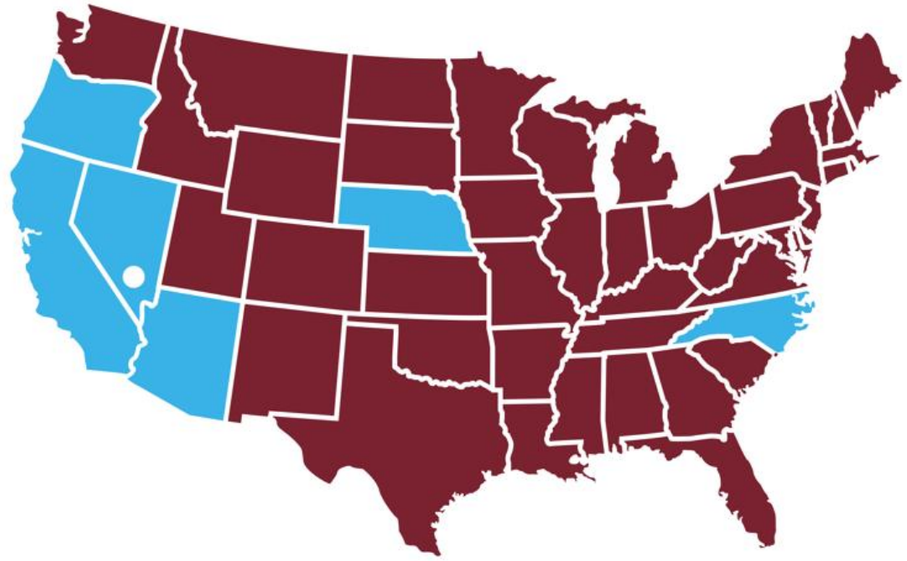
P3 Health Partners at a Glance

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.



140K **Total Lives**
~110K At-Risk Lives
~30K 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

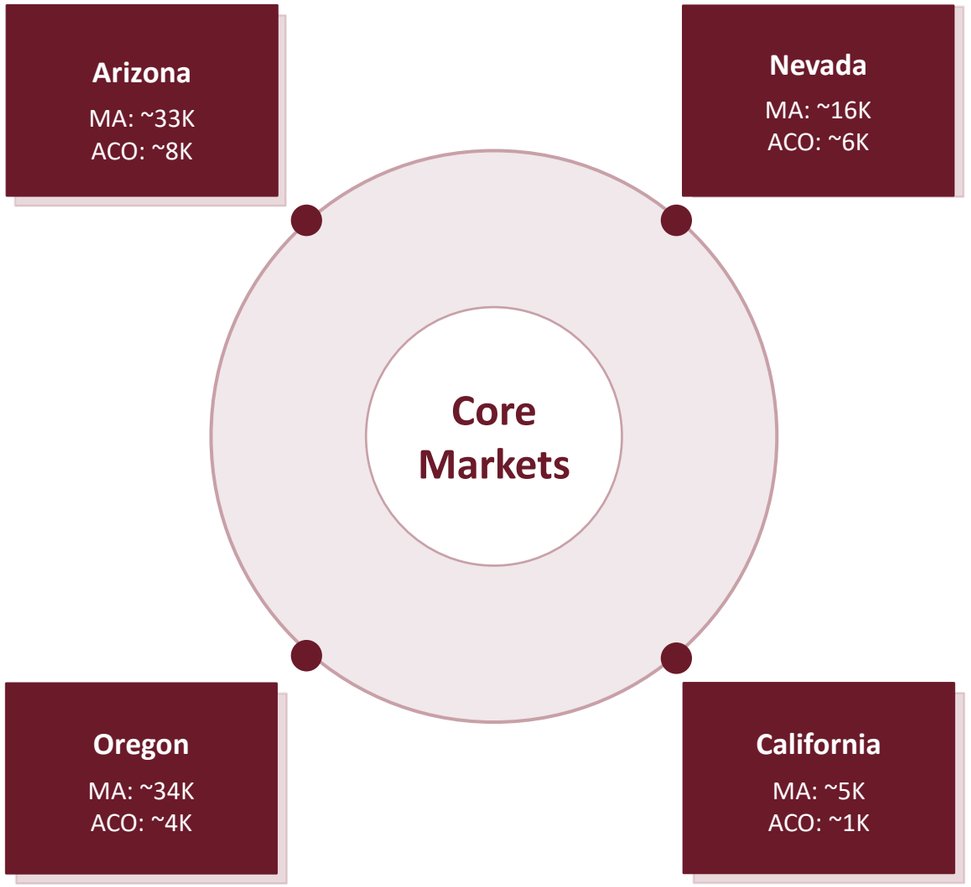
The operating expense and contract work completed in 2025 is embedded in the business entering 2026. Renegotiated payer arrangements, a leaner operating structure, and improved provider accountability have reset the financial baseline.

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

Delegated Operations

- Establish clinical & operational infrastructure
- Take on delegated functions prior to full risk
- Performance monitoring and data integration
- ~$30M revenue contribution

Phase 2
2027

Expanding Delegation

- Assume delegation for claims processing and payment
- Deepen clinical integration
- Demonstrate quality metrics and cost management
- Partner on benefit design and bid strategy

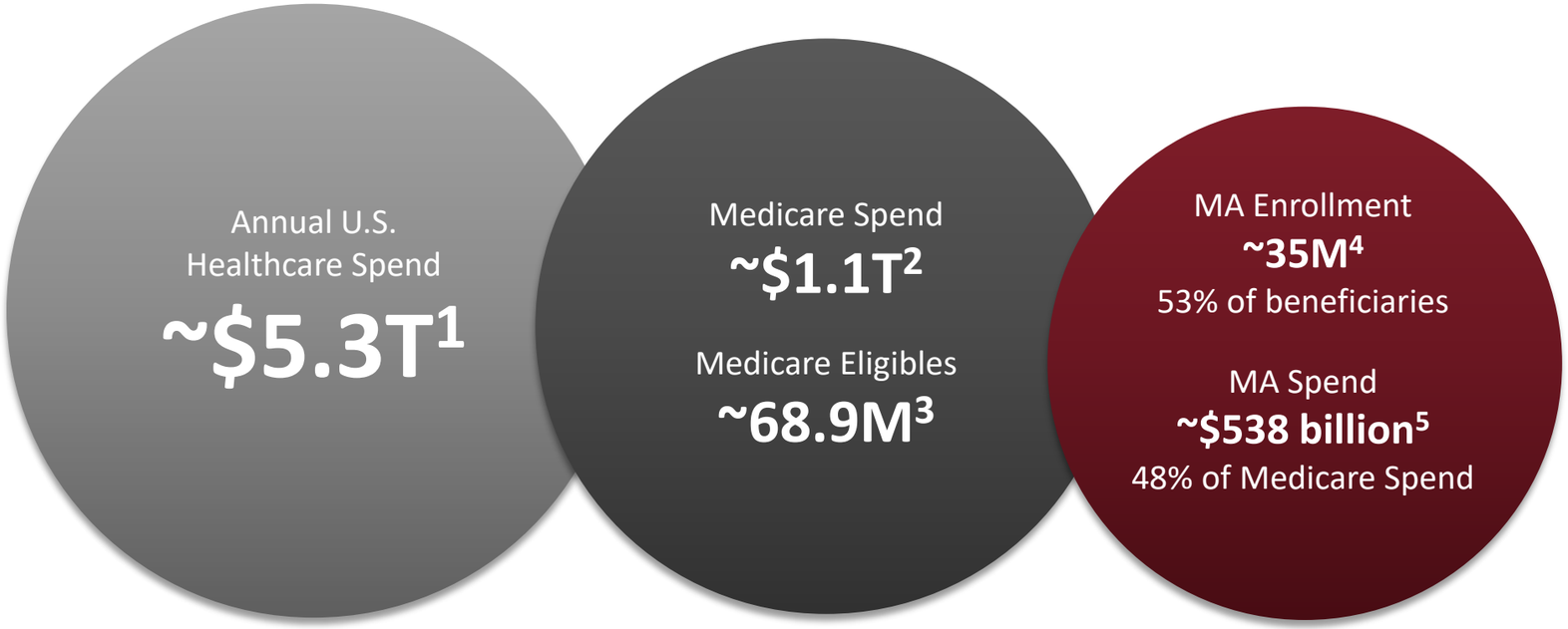
Phase 3
2028+

Full Risk

- $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



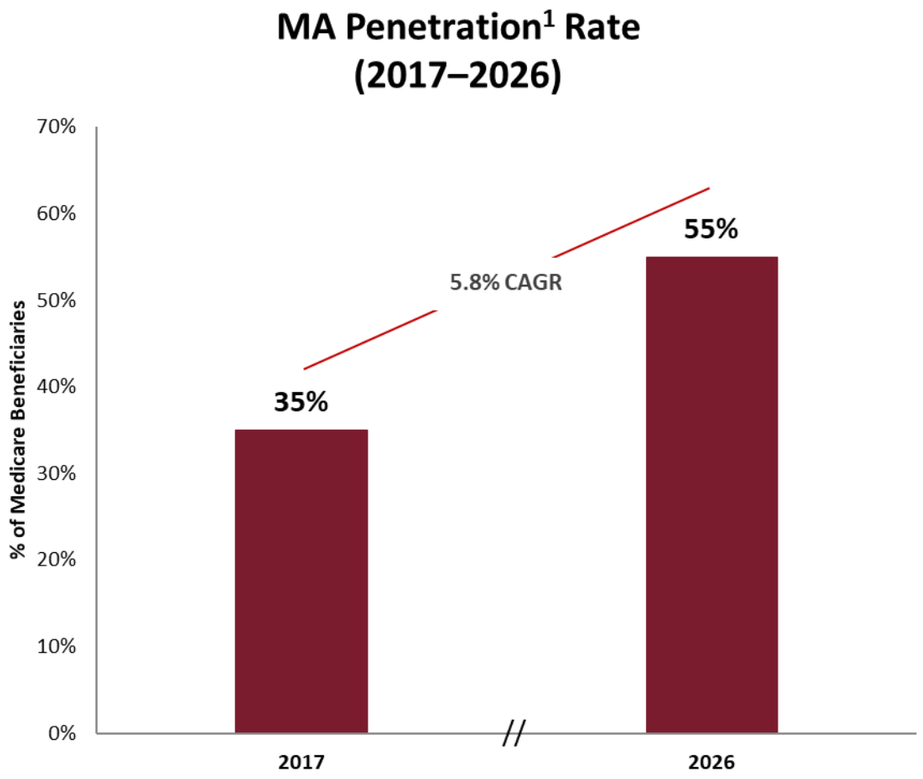
Industry Shifts Driving Opportunity for P3

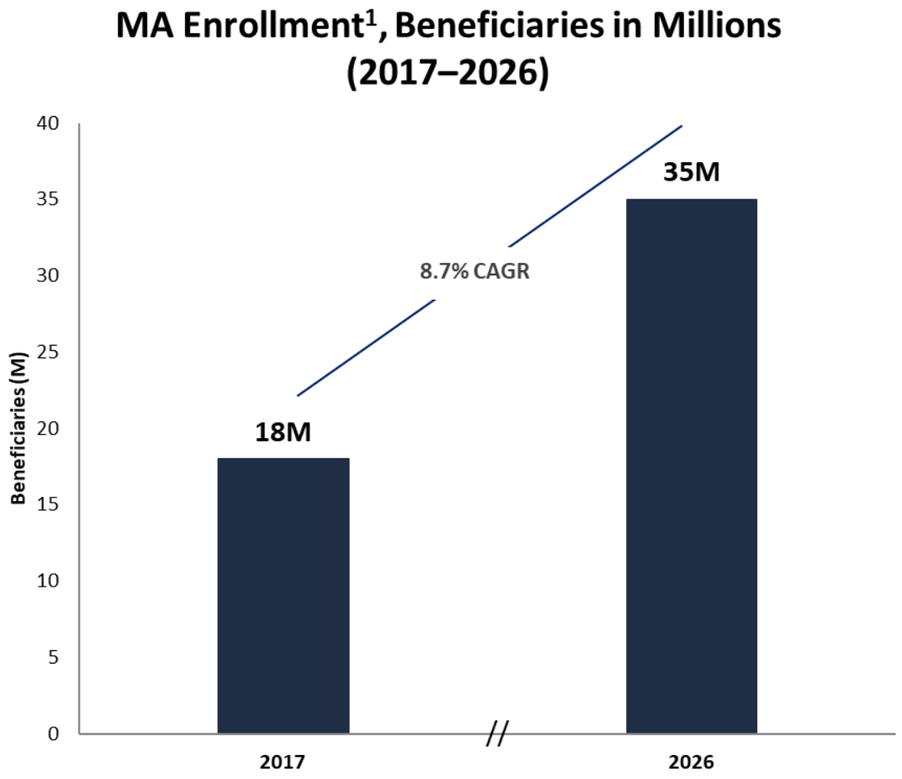
High Medicare Spending	Payor Cost Pressure	MA Rate Recovery	Industry Consolidation	Macro Tailwinds
Need for Controlled Cost Platform	Increased Demand for P3	Margin Expansion	Partnership Pipeline	Expanding Addressable Market

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

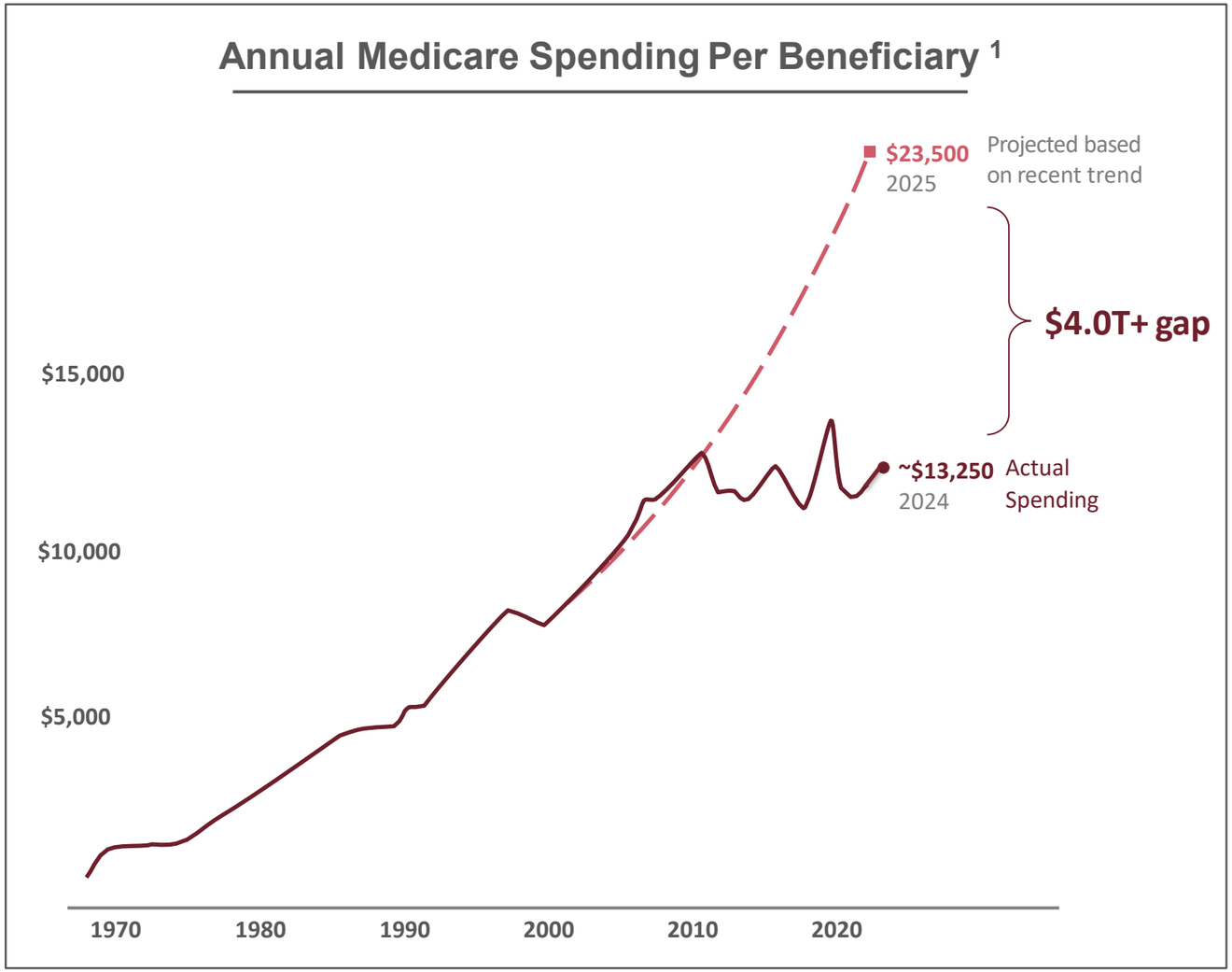
Medicare spending **in total** has increased dramatically as more beneficiaries age in,

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	Poor Quality of Care and Clinical Outcomes	Inadequate Access to Primary Care	Physician Burnout
$1.1T	**42%**[3]	**~33%**[4]	**~50%**[5]
US spending on Medicare (2024)[1]	of Americans have 2+ chronic conditions	Americans do not have access to essential primary care	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[2]

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

Footnotes: 1) 2024 KKF 2) 2019 Census.gov 3) CDC.gov 2024 4) 2018 Medical Economics 5) 2025 ama-assn.org

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

1 Building the Foundation

Early Momentum, Lasting Results

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

2 Empowering the Network

Unlock network potential for measurable outcomes

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

3 Optimize Performance

Strengthening the PCPs Performance

- 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

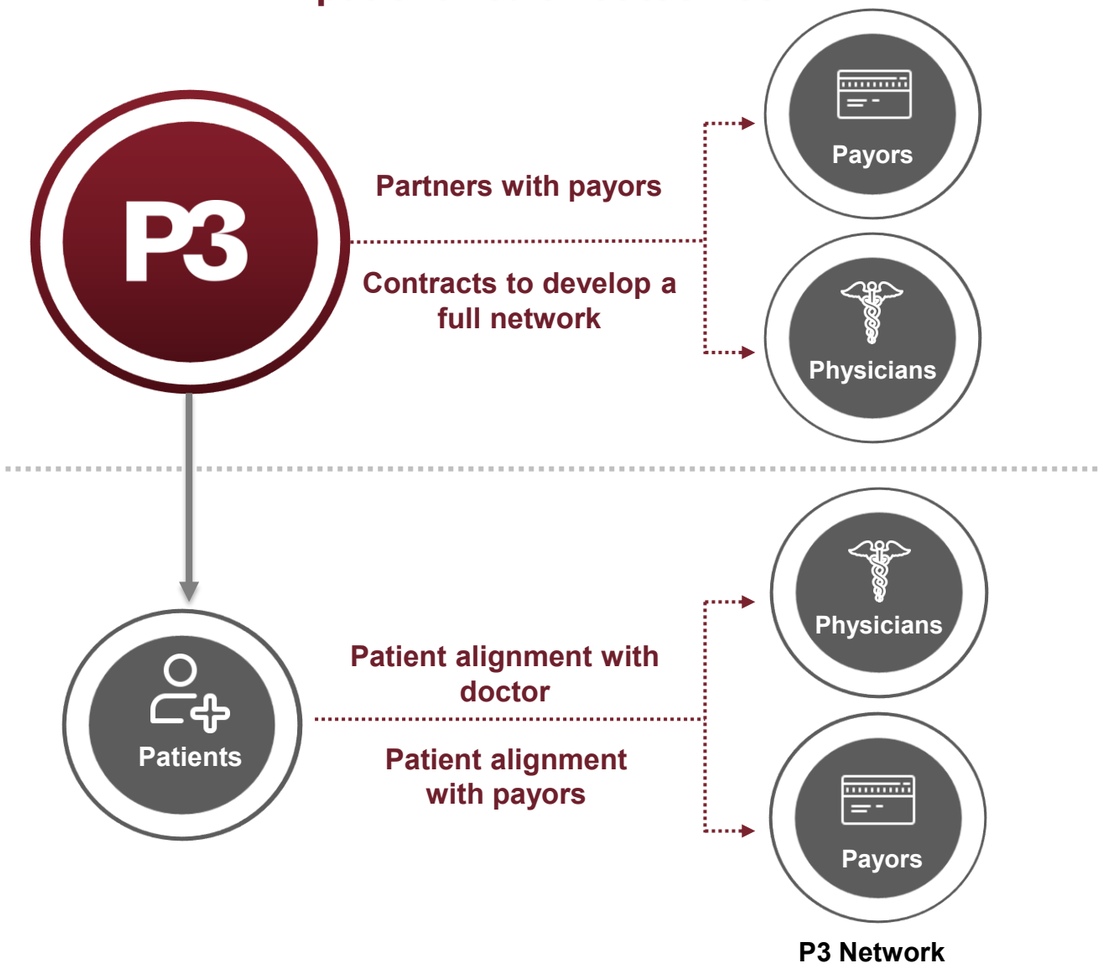
4 Full Risk Transition

Glide Path to Risk

- 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 inventive (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

The Starting Point

- Unfavorable contract economics across key payer relationships
- Provider network lacking accountability and value-based alignment

Baseline Conditions

- Limited visibility into utilization and claims performance
- Operational infrastructure not scaled for value-based risk

2024

New Leadership Team

- CEO and CFO transitions completed (Q2 and Q3 2024, respectively)
- Contract restructuring and strategic reset initiated

Network Realignment

- Provider network concentrated toward Tier 1 provider groups
- Care Enablement Model deployed

2025

Operational Efficiencies

- Eliminated duplicative corporate infrastructure
- Investment in key talent across Legal, Contracting, and Finance
- Contract restructuring of key payer relationships

Quality & Star Performance

- 4-Star status across ~70% of priority MA plans
- Tier 1 network expanded to 50%+ of members
- Complex Care program scaled

2026

Contracts Inflecting

- $125M revenue & contracting improvement embedded
- New MA geography adds ~30k lives with positive cash flow and EBIDTA

Path to Profitability

- Adjusted EBITDA guidance: ($20M) to $40M
- $170M year-over-year EBITDA improvement

2026 Outlook: Structural Repositioning Drives Improvement

2026 Guidance range of ($20M) to $40M represents a ~$170M improvement to the midpoint of $10M

Revenue & Contracting	Operational Execution	Payer & Mix
75% of improvement	20% of improvement	5% of improvement
Contract restructuring, bid optimization, favorable CMS benchmark	Medical cost management and network contracting	Benefit design and membership mix changes

2026 Guidance		
Metric	**Low**	**High**
At-Risk Members	107,000	117,000
Total Revenues (in millions)	$1,500	$1,700
Medical Margin (in millions)	$160	$200
Medical Margin PMPM	$120	$150
Adjusted EBITDA (in millions)	($20)	$40

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?