P3 Health Partners

People. Passion. Purpose.

Investor Presentation
September 2025

Disclaimer and Forward-Looking Statements

This presentation has been prepared by P3 Health Partners Inc. (“P3,” the “Company,” “we” or “us”) and is made for informational purposes only to familiarize yourself with the Company. This presentation does not purport to be all inclusive or to contain all of the information the recipient may require in connection with an investigation of the Company. Nothing contained in this presentation is, or should be construed as, a recommendation, promise or representation by the Company or any officer, director, employee, agent, affiliate, representative or advisor of the Company. The Recipient should not construe the contents of this presentation as legal, tax, accounting or investment advice or a recommendation. This presentation is neither an offer to sell or purchase, nor a solicitation of an offer to sell, buy or subscribe

Forward-Looking Statements and Other Information

This presentation contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, Section 21E of the Securities Exchange Act of 1934, as amended, and the Private Securities Litigation Reform Act of 1995, as amended. Words such as "anticipate," "believe," "budget," "contemplate," "continue," "could," "estimate," "expect," "indicate," "intend," "may," "might," "plan," "possibly," "potential," "predict," "probably," "project," "seek," "should," "target," or "will," or the negative or other variations thereof, and similar words or phrases or comparable terminology, are intended to identify forward-looking statements. These forward-looking statements address various matters, including the Company’s future expected growth strategy, operating performance and cost savings initiatives, all of which reflect the Company’s expectations based upon currently available information and data. Because such statements are based on expectations as to future financial and operating results and are not statements of fact, actual results may differ materially from those projected or estimated and you are cautioned not to place undue reliance on these forward-looking statements. These forward-looking statements are not guarantees of future performance, conditions, or results, and involve a number of known and unknown risks, uncertainties, assumptions and other important factors, many of which are outside the Company's control, that could cause actual results or outcomes to differ materially from those discussed in the forward-looking statements.

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.

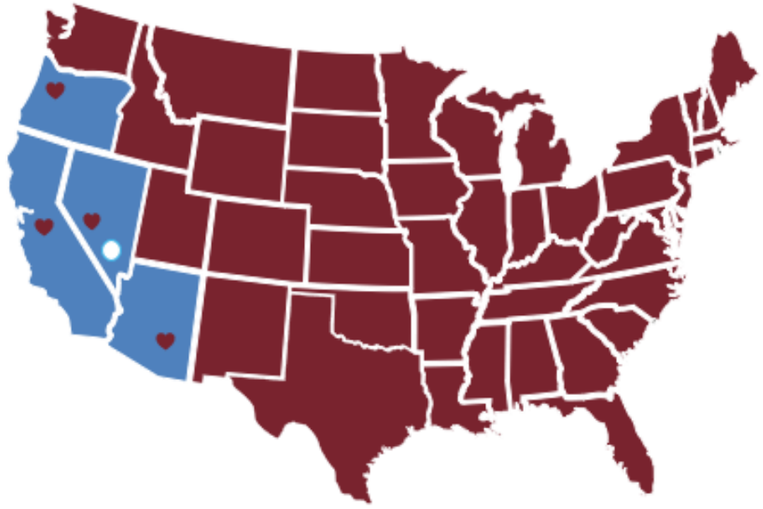
Industry and Market Data

Certain information contained in this presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources and the Company’s own internal estimates and research. While the Company believes these third-party sources to be reliable as of the date of this presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. In addition, all of the market data included in this presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Finally, while we believe our own internal estimates and research are reliable, such estimates and research have not been verified by any independent source.

.

P3 Health Partners at a Glance

P3 Health Partners is a physician enablement organization that takes global risk in a rapidly growing $1.1T 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.

115K **Full-Risk Lives Managed**
~17K ACO Reach lives

4 Western States

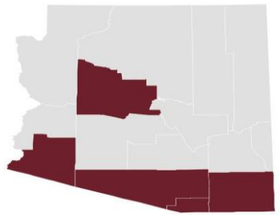
2,800+ **Primary Care Providers**

18 **Payor Partners**

P3 Expansion Within Existing Markets and Counties

Expanding Density in Existing Markets:

Arizona



22% market share
53K enrolled members

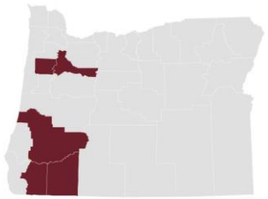
Nevada

9% market share
31K enrolled members

San Joaquin County, CA

10% market share
8K enrolled members

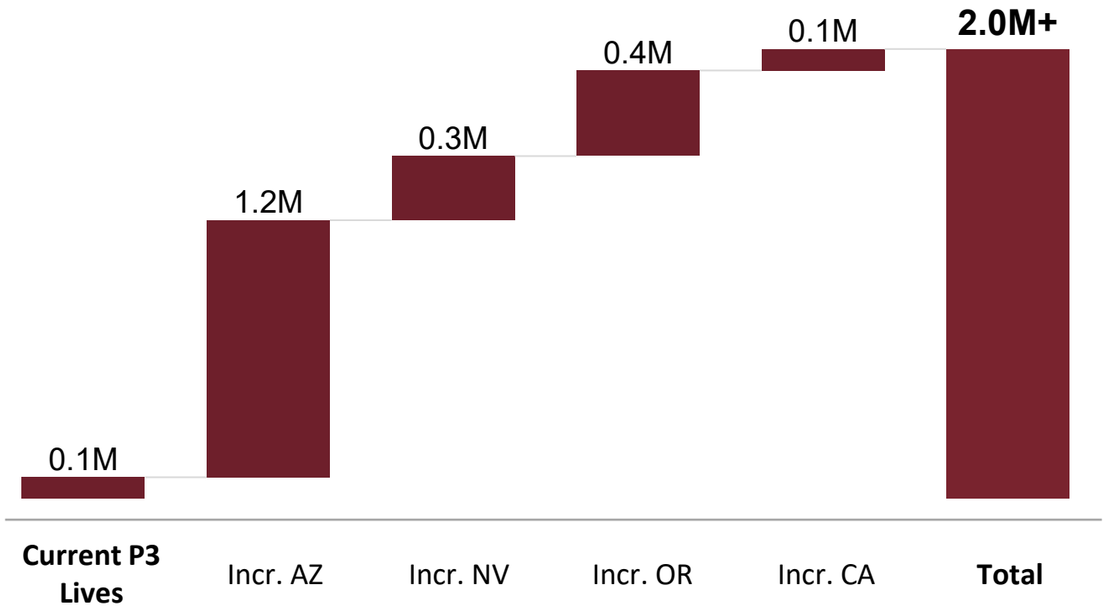
Oregon



28% market share
32K enrolled members,

P3 is focused on the counties where its providers are most effective in driving clinical outcomes

Growth Potential in Existing Counties[1]:



Current P3 Lives by State

Arizona: 53k (43%) **Nevada:** 31k (25%) **Oregon:** 32k (26%) **California:** 8k (6%)

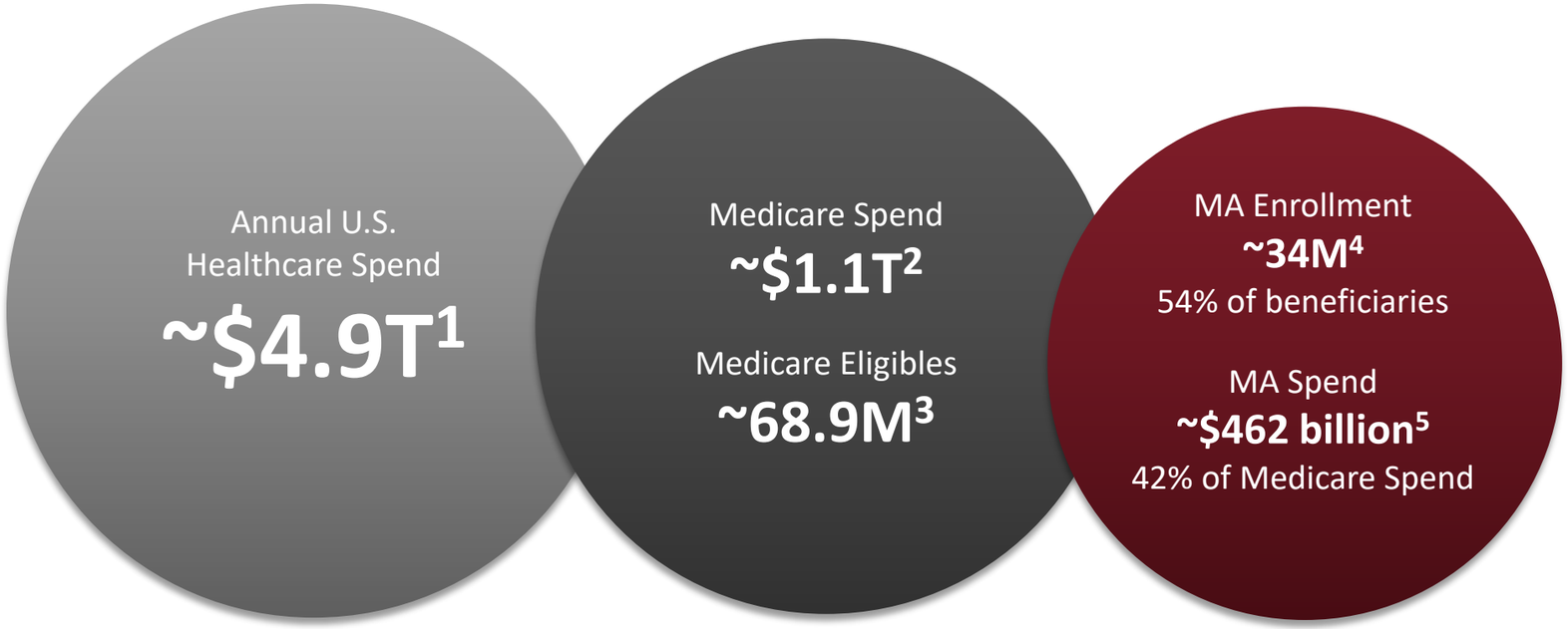
~2M Medicare Lives Represented in PCP Network

[1]**Assumptions:** 3,075 PCPs in P3's IPA Network; Each PCP to have ~650 Medicare lives per panel (Representing 2M Medicare lives in P3 PCP network; ~325 MA per panel); Incremental opportunity for Medicaid (600 per panel) and Commercial (600 per panel)

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

- **Large and rapidly growing total addressable market** in taking full risk with providing senior care to Medicare lives
- **Pathway to profitability** driven by a focus on execution to drive long-term value for all stakeholders
- Compelling **fully delegated risk model** leveraging data and technology, to deliver better clinical outcomes at lower costs with better patient experiences and greater professional satisfaction
- **Scaled networks of deeply-integrated and capital efficient care models** into highly attractive geographic markets
- **Experienced leadership team** with long tenure in value-based care across the executive and physician leadership that translates into industry high retention rates

P3 is Addressing a Substantial Market Opportunity



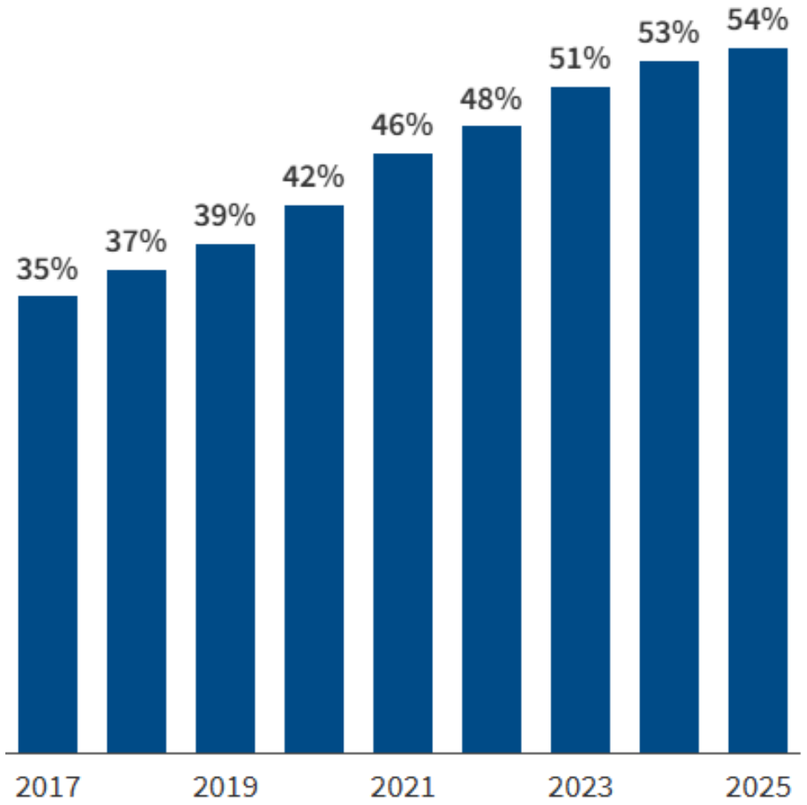
Industry Shifts Driving Opportunity for P3

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

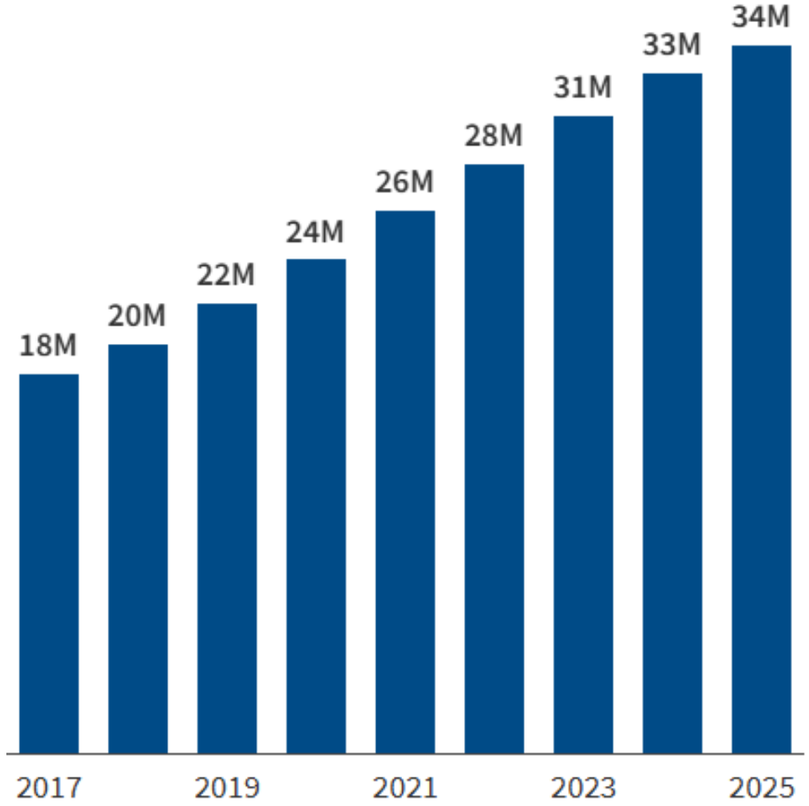
Footnotes: 1) CMS.gov 2023 2) 2024 KKF 3) CMS.gov May 2025 4) Kff.org 2024 5) MedPAC report to congress, March 2023

2025 MA Enrollment Reaches 54% Penetration

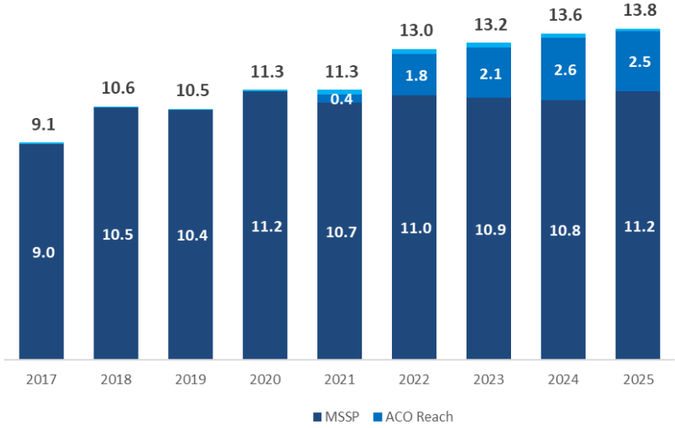
Demonstrates the potential impact from more rational benefit designs



Medicare Advantage Penetration [1]



Medicare Advantage Enrollment [1]



ACO Enrollment [2]
(Beneficiaries in Millions)

Footnotes: 1) KKF: Medicare Advantage in 2025: Enrollment Update and Key Trends 2) CMS

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

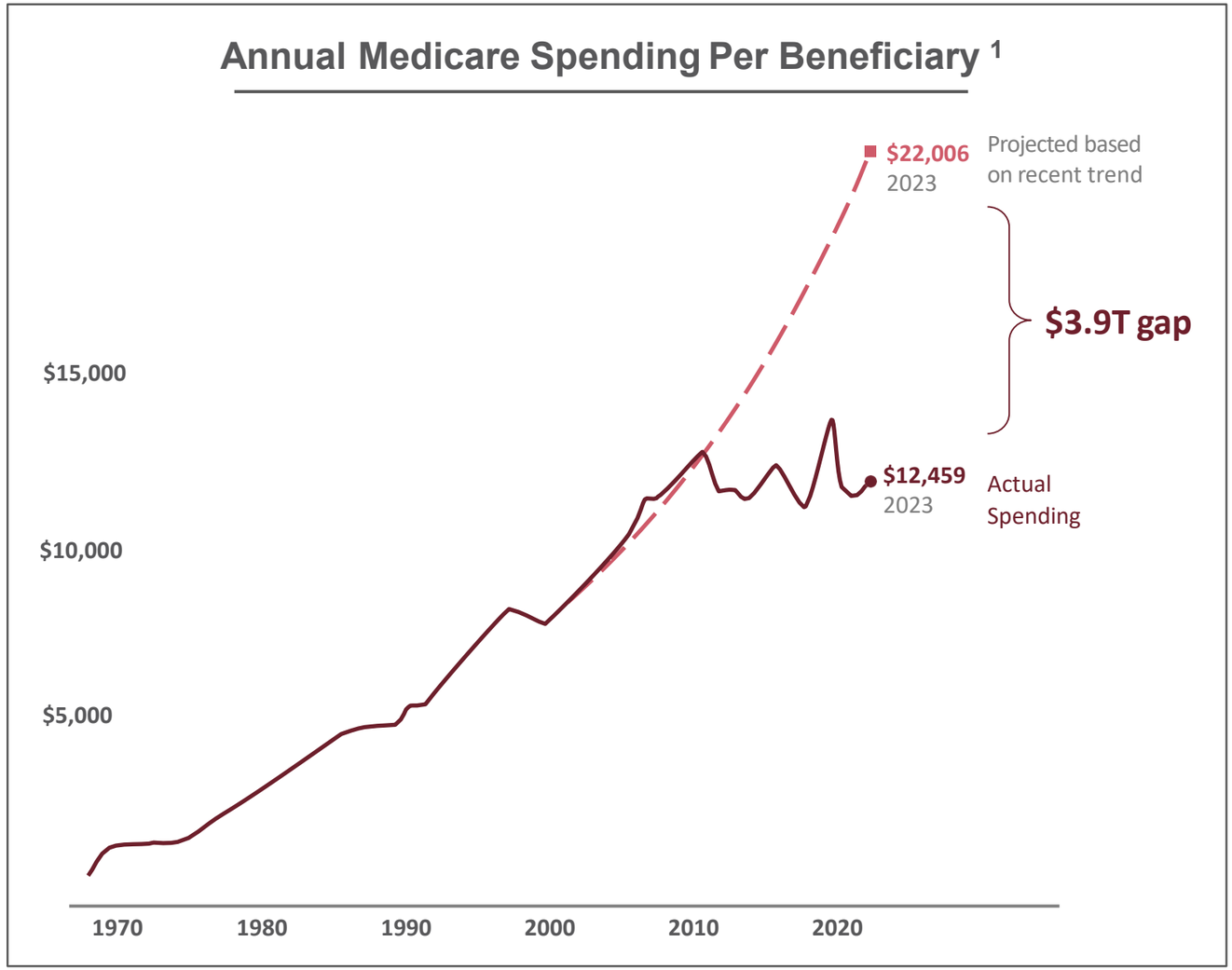
Medicare spending **in total** has increased dramatically as more beneficiaries age in,

however

Per beneficiary spending has been ~30% below the projected trend since 2012

amounting to a

$3.9 trillion spending gap
from the projected trend, highlighting value-based care's contribution in bending the cost curve.



Footnote 1: NYT "A Huge Threat to the US Budget has Receded. And No One Is Sure Why." Published 2023.

P3's Solution to Industry & Status Quo Challenges

CHALLENGES

1. **PHYSICIANS**
   Lack resources / expertise for value-based care transition
2. **PAYORS**
   Need demonstrable ROI from value-based contracts
3. **HEALTH SYSTEM EMPLOYED PHYSICIANS**
   Primary care typically operates at a loss
4. **FRAGMENTED LOCAL MARKETS**
   Disconnected PCP groups creating care coordination gaps

P3 SOLUTIONS

1. **PHYSICIAN PARTNERSHIPS**
   Deliver proven 98% physician retention through enhanced support
2. **PAYER PARTNERSHIPS**
   Deliver measurable cost savings while driving enhanced quality outcomes
3. **HEALTH SYSTEM COLLABORATION**
   Provide proven VBC expertise and risk-sharing framework
4. **INTEGRATED NETWORK SOLUTIONS**
   Create unified, proactive care networks with coordinated touchpoints

Footnotes: 1) 2024 KKF 2) 2024 KFF

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

CARE MANAGEMENT

- 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

Data 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

- Data-driven decision support with proven clinical impact
- 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

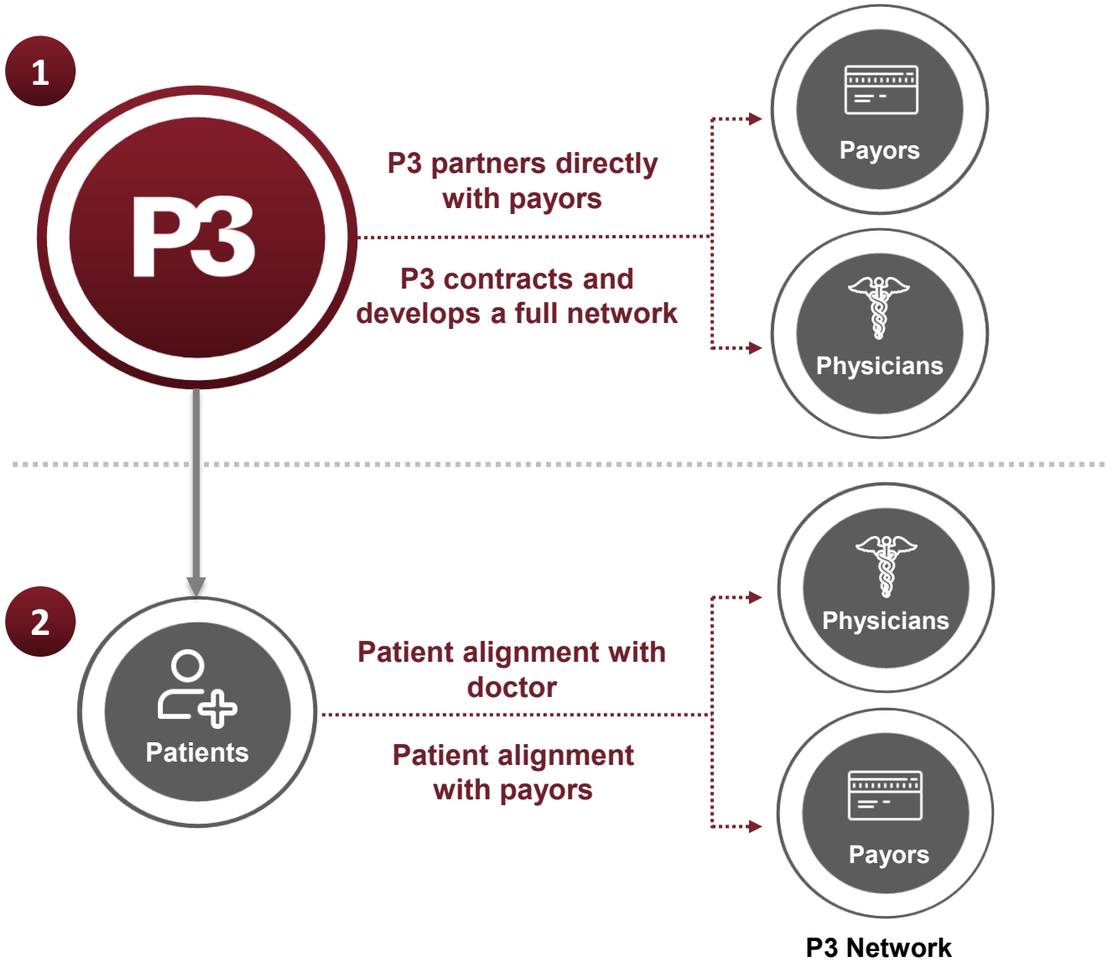
- Plan and implement Practice support services and clinical programs
- Establish performance reviews and real-time interventions
- Coaching for results and impact
- Influence referral patterns to higher quality – lower cost specialists and facilities

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 drives coordinated 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.

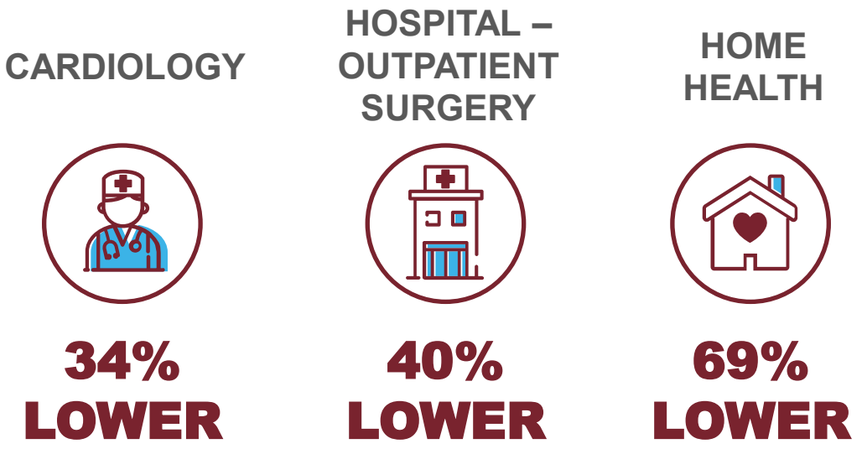
Status Quo Patient Journey:

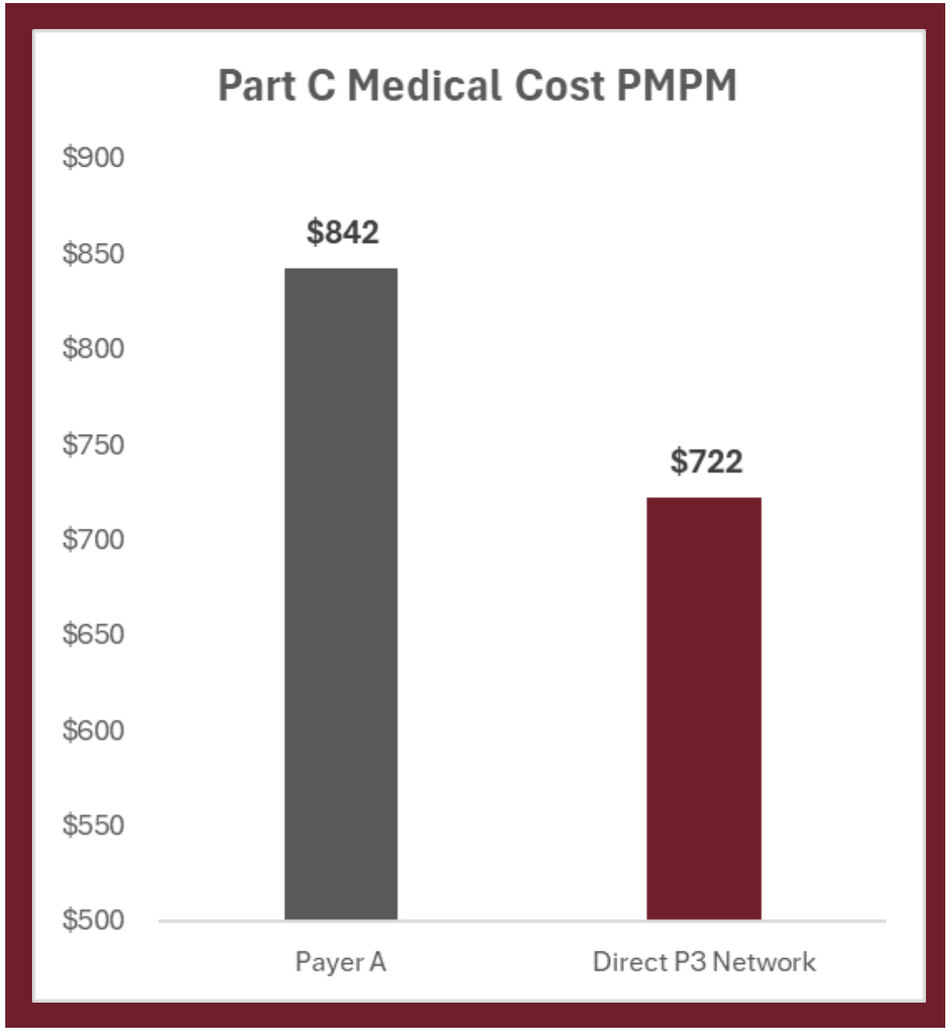
1. ***Unconnected choices*** *– the plan and PCP are not connected by a shared risk model*
2. ***Misaligned Incentives*** *– health plan's goal (manage cost) and provider inventive (more services) are at odds creating inefficiency*
3. ***Reactive, Episodic Care*** *– care is delivered and paid for on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

Case Study: Medical Cost Reduction

In 2024, the P3 Direct Network had a **$120 PMPM, or 14.3%,** lower Part C Medical Cost PMPM than Payer A members.

Applying these savings to the 12.5K Payer A members would equate to a **~$18M medical cost reduction**.





Excludes: Dental and Primary Care from analysis.

2025 Progress on $130M+ EBITDA Growth

Publicly reported on Q3-24 Earnings Call; expected realization in 2025E

1 Operational Efficiencies

- Re-structured operational deployment
- Removed redundancies and inefficiencies

$20M+ *EBITDA Opportunity*

$20M in EBITDA contribution completed

2 Contract Rationalization

- Reduced unprofitable payer contracts
- Eliminated unprofitable physicians from network

$35M+ *EBITDA Opportunity*

$35M in EBITDA contribution completed

3 Revenue Optimization

- Vendor deployment and re-tooling at POC
- Accessing members through multiple touchpoints to optimize risk adjustment

$75M+ *EBITDA Opportunity*

In process

Near Term Initiatives to Drive EBITDA

Star Ratings
Aiming for care quality gaps & HCCs

Network Rationalization
Optimizing provider and payor contracting

Smart Growth
ACO Reach & increased member penetration

Operational Efficiencies
Improved tools to drive provider engagement

2026 EBITDA Opportunities and Industry Tailwinds

EBITDA Opportunity of $120M-$170M in 2026+

1

Base Rate & Burden of Illness

- 2026 CMS base rate final notice
- Improved alignment with population burden of illness

40% *Of EBITDA Opportunity*

2

Operational Performance & Medical Management

- Utilization Management
- COPD
- End of Life Care

30% *Of EBITDA Opportunity*

3

Contract & Network Management

- Carry-forward from 2025 payer renegotiations
- Provider network maintenance

20% *Of EBITDA Opportunity*

4

Market Dynamics

- Product offering shifts from Payers
- Payer Benefit Design

10% *Of EBITDA Opportunity*

Industry Tailwinds

Strong, sustained enrollment growth in MA
MA enrollment projected to exceed 55% of all Medicare eligible in 2026

Favorable base rate environment
CMS 2026 Final Notice signals improved reimbursement and stability

Market stabilization and rationalization
Payers offering fewer PPO plans and pulling back on overly rich benefit designs

Outlook for 2025

2025 Guidance		
	Low	**High**
At-Risk Members	109,000	119,000
Total Revenues (in millions)	$1,350	$1,500
Medical Margin (in millions)	$124	$154
Medical Margin PMPM	$90	$111
Adj. EBITDA	$(69)	$(39)

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?