MAXICARE HEALTHCARE CORPORATION

MINUTES OF THE EXECUTIVE COMMITTEE MEETING

Boardroom, Maxicare Tower
203 Salcedo Street, Legaspi Village, Makati City[1]
22 May 2024, 8:00 AM

PRESENT:

ANTONIO L. GO
LANCE Y. GOKONGWEI
ROBERTO M. MACASAET, JR.
BRIAN M. GO
ESTHER WILEEN S. GO
RENE J. BUENAVENTURA
MICHAEL P. LIWANAG

ALSO PRESENT:

CHRISTIAN S. ARGOS
MARIA TERESITA A. ESPALLARDO
JASPER HENDRIK T. CHENG
GULLY GO
JOE MERRITO P. BUOT
FIONA MARIE L. VICTORIA
RODELEE UY
JOSEPHINE LOPEZ
JOSE PASTOR Z. PUNO
ANTHONY PEREZ
ELIZABETH GREGORIO
NEDINO LESTER CAYETANO
JERRY PEREZ
MARK MACAPAGAT
KURLEIGH GACUTAN
ATTY. ALEXANDER ERESE
ATTY. JOANNE CO PUA
ATTY. KYLE BOLLOZOS
ROCKY DE CASTRO
MARIA FE AGNES BATUNGBACAL
MIKE MANRIQUE
MEG YAP-AGUINALDO
RACQUEL ADORABLE
JUN MARASIGAN
JENINA JOY MALAPITAN
MERIZA MAMARIL
LAURENZ DALANGIN
ATTY. DANNY E. BUNYI
ATTY. JANNA MAE B. TECSON
ATTY. MARY ZOELLI R. VELASCO
ATTY. NINNA A. BONSOL
MARIA ESTRELLA GARCIA
RIZ GAURAN
BOSTON CONSULTING GROUP

[1] The meeting was also attended virtually by some Committee members / members of the Senior Management Team through video conferencing (Zoom video conferencing).

I. Call to Order

Mr. Antonio L. Go ("Mr. Go"), called the Executive Committee (the "Committee") meeting to order and presided over the same. The Corporate Secretary, Atty. Danny E. Bunyi, recorded the Minutes of the proceedings.

II. Certification of Quorum

The Secretary certified that notices were sent to all the members of the Committee in accordance with Maxicare Healthcare Corporation's (the "Corporation" or "Maxicare") By-Laws. The members who attended virtually were instructed to turn on their video and audio for verification of their identity and presence, as well as for confirmation that their video and audio were functioning. Since all the members of the Committee were present, the Secretary certified the existence of a quorum for the transaction of business at hand.

III. Approval of the Minutes of the Previous Meeting

Upon motion duly made and seconded, and there being no objection, the Committee approved the previous Minutes of the Executive Committee Meeting dated 17 April 2024.

IV. Reports

i. OGSM[2] Updates: Organizational Transformation

Boston Consulting Group ("BCG") presented the progress of Maxicare's Transformation Initiatives.

As to the 2024 YTD[3], there has been a continual positive trajectory in value accrual and YTD financials.

With respect to IC1[4], both TCV and CM[5] have improved significantly since last year with Maxicare Plus repriced, *viz*:

TCV	
January to April 2023	***January to April 2024***
Php 8.6 Billion	Php 10.7 Billion
Pricing CM	
January to April 2023	***January to April 2024***
11%	16%

[2] OGSM: Objectives, Goals, Strategies, Measures
[3] YTD: Year To Date
[4] IC1: Impact Center 1
[5] CM: Contribution Margin

The Price increase and revised rating mechanism for Maxicare Plus were also reported as follows:

(1) 15% price increase on the main pool for H2 2024 renewals;
(2) Introduced substandard ratings to apply higher price increases for SMEs with continuously high loss ratios for two (2) years; and
(3) Balanced approach was taken to preserve quality accounts while improving product profitability (transfer to corporate now impacts 4% of accounts while it was 18% before).

As regards IC2[6], it was reported that negotiations have been on the long tail, with efforts shifting to rates enforcement and preferred provider tiering as follow-through to curation. This would allow the capability of being able to differentiate between the providers which were giving better offers that are good vis-à-vis those providers which were not giving good offers.

This has secured annualized impact with currently enforceable. This was reported as a significant progress due to closer coordination between Maxicare teams and stricter monitoring of providers.

It was further discussed that significant leakage from enforcement issues have been identified (i.e., LOAs not being able to issue the correct amounts), which strengthened efforts to focus on the institutionalization of stricter governance of Maxicare agents and providers.

Moreover, benefits for preferred providers and steerage controls have been defined. This was for pilot to concretize value in exchange of preferential rates and discounts obtained.

In terms of steerage providers, Mr. Antonio Go ("Mr. A. Go") raised that he was not sure if the current efforts were the right courses of action. He was concerned about the efforts to obligate the providers to agree to the terms and conditions, because should they not accept, the members would have no other choice but to go to a different provider. He pointed out that the efforts might not yield a balanced equation.

Mr. Christian Argos ("Mr. Argos") explained that the resort to the current efforts was because of their extreme situation. What they have done in the past has not worked, and they deemed the same as having set a strong signal to initiate conversations with the providers. As of date, because of the current efforts, they have not been met with situations where the provider was unwilling to have conversations with Maxigroup.

Mr. A. Go inquired whether there was a way to help members to go to other providers. Mr. Argos confirmed that alternative advice had always been given to

[6] IC2: Impact Center 2

the members. The members are aided such that assistance in terms of scheduling to lessen inconvenience had been provided.

Mr. Argos explained that the blacklist was reserved for the most extreme of cases, which does not happen anymore. Providers are classified as green list, so members are not sent there.

Essentially, four (4) tiers of providers have been defined: (1) Greenlist – preferred, (2) Whitelist – accredited, (3) Graylist - member LOA only, and (4) Blacklist – suspended/disaffiliated.

Mr. A. Go raised the need of finding a solution on how to ensure compliance by the providers, particularly ensuring compliance while maintaining good public relations.

The Cumulative annualized incremental CM as implemented was reported as follows:

End-April: ~1.82 Bn annualized impact implemented;
Over Q2/Q3: Implemented impact expected to reach ~2.2 Bn

Cumulative annualized incremental CM (PHPm) Implemented

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Remarks
IC 1: Renewals and Repricing	Target										
	Actual (Total)										
	• Top 50 accounts										
	• Other accounts										
IC 2: Provider Network Optimization	Target										
	Actual (Total)										
	• Uploaded & Archived										
	• Negotiated, not yet uploaded & archived										
Total	Target										
	Actual										

XXX: Target XXX: Actual at or above target XXX: Actual below target

Note: Attribution to month done as follows: IC1 - based on new contract effective date; IC2 - based on when revised rates are in Payorlink

On the repricing and renewals impact center, reviews have been made regarding the largest corporate accounts and their upcoming renewals from April to May 2024:

However, most of the accounts were actually negative CM accounts. The team has been trying to look for options to either redefine the benefits and negotiate different kinds of payment terms with these accounts to try to keep them with Maxicare.

Renewals compared with last year have also been continually tracked:

Overview of 2024 NCV Funnel - Corporate Full Risk

Net Contract Value (NCV) & Contribution Margin (CM) Amount in Php Millions

Effective Date	Renewed Business			New Business			2023 Total Renewed and NB			Did Not Renew	
Month	NCV	CM	CM%	NCV	CM	CM%	NCV	CM	CM%	NCV (expiring)	CM (expiring)
January											
February											
March											
April											
2024 YTD TOTAL											
2023 YTD TOTAL											

Mr. A. Go inquired as to the percentage of repricing vis-à-vis the current number of accounts. It was reported that the current repricing was at (40% were for the accounts in January, and 10% to 20% for February to April.)

Mr. A. Go, additionally asked how many repriced accounts have been profitable.

It was explained that there were several accounts which were still within 1% to 2% of the pricing CM. In repricing, the target was CM. From experience, the valiance from CM spanned to around . The actual CM was anywhere from fourteen (14) to eighteen (18) CM.

Mr. Brian Go ("Mr. B. Go") clarified that two steps were undertaken in repricing: (1) Reprice; and (2) Actuals. In Actuals, the team cannot ensure that the actuals would meet what was forecasted. On a forecasted basis, however, the CM had been moved to

Mr. Argos clarified that in terms of pricing discipline that was implemented, the Actuals are closer to profitability than expected but there are still risks (i.e. Covid is back). He noted, however, that they could do better.

Mr. A. Go asked for the reason why membership was not increasing. Mr. Argos discussed that in the renewal cycle, accounts have been lost with negative CM and they were not willing to match the price. By next year, the expectation would be that whoever got these accounts would jack up the price. Hence, the team would be able to get these accounts back after one (1) year similar to what happened with BPI and others after the 1-year cycle.

Mr. A. Go raised a query as to what interventions could be done for their existing accounts to make sure that they do not disappear and that the group would not continue to lose money.

Mr. Argos suggested to build more clinics. Mr. A. Go requested for a faster solution. Mr. Argos explained that efforts to build more clinics were being expedited.

Mr. A. Go raised that he was thinking of a more proactive approach – that is, coming up with preventive solutions (i.e., keeping the members healthy even before going to the hospital).

A BCG representative commented that the economics in the program were such that they would only pay off if the members would stay for five (5) to ten (10) years (i.e., diabetes prevention).

Mr. B. Go noted that one of the issues in the Philippine context of HMOs[7] was that the current renewals were for one (1) year only which could not yield the benefits aimed in preventive cases. It was explained that such renewals resulted to very leaky savings.

As to solutions, Mr. Argos discussed that certain measures were being undertaken such as the annual retrieval reprice so there was a certain level of protection.

Mr. Argos further explained that efforts to move out of the insurance machinery might be done in the next twelve (12) to eighteen (18) months so that they could enter into longer term contracts.

Mr. A. Go further noted that the turnover rate was very high.

Mr. A. Go raised that he did not know the average turnover with respect to the BPO Account. Mr. B. Go suggested to capture the database of the ultimate member. Mr. Argos raised that CCAP has a database of agents (i.e., negative list). There was interest regarding the same but no real efforts have been exerted to

[7] HMO: Health Maintenance Organization

include health as there were privacy concerns. BPOs were concerned about an agent committing fraud and moving to another BPO, and the same have been used for recruitment already.

With this, Mr. Argos inquired whether they should already include the view on health. Ms. Esther Wileen S. Go ("Ms. Go") added that databases are in place if the members moved from one company to another. Mr. B. Go noted that the databases are a good start and that these can be built up. Mr. A. Go concluded the discussions by raising that he was not happy with current efforts, and that more solutions must be undertaken.

It was further reported that aside from the corporate accounts, another initiative which was being done was refinement of the pricing for the SME business. In relation to the Maxicare Plus portfolio, policies have been put in place last year to try to identify members with consistently high loss ratios. Efforts have been undertaken to refine that methodology to ensure that the pricing was fair, and that a good account does not get a disproportionately high increase, thus trying to keep the increases stable and the portfolio profitable.

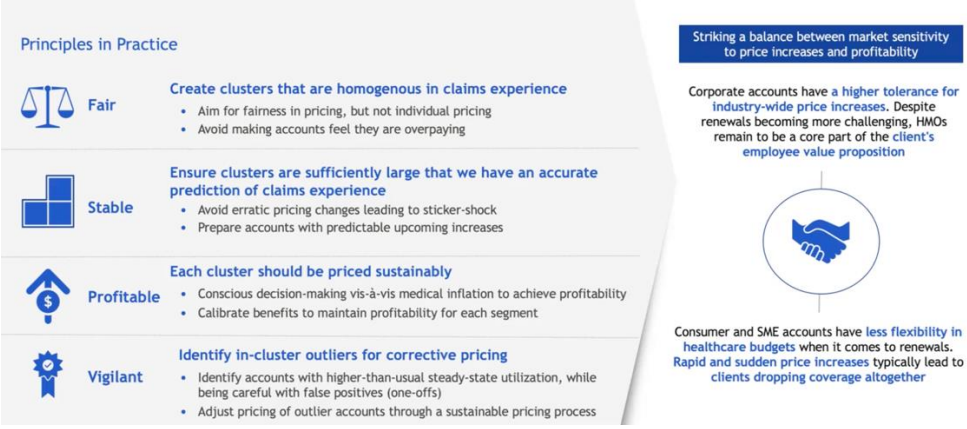
It was noted that price increases on the SME segment were a bit more sensitive to the clients compared to that of the corporate accounts. There were cases where, given the very high price increases, an SME could actually choose not to have coverage at all, unlike in the corporate side where they would just opt to look for another HMO platform from a competitor.

Mr. B. Go noted that the SME Account was not a good opportunity area because they may not have a corporate clinic. Mr. Argos added that they do not meet the DOLE[8] thresholds.

Mr. Argos clarified that the practice before was that when an account with around twenty (20) people had a high loss ratio, its coverage was terminated. Now, a longer term view was taken on the prices.

As to the pricing principles for Maxicare Plus, Mr. B. Go inquired whether the below practices were observed as having been done successfully in other markets:

[8] DOLE: Department of Labor and Employment



It was confirmed that the SME could be priced in the same manner as a large corporate account. A lot of variables have to be considered – such as the need for clustering. There was a need for a certain number of concerns per year of claims data in order for the claims experience to be statistically valid. To be able to get the percentage, the several SMEs must be grouped together, and a single SME could be observed over a longer period of time. They would then search for clusters that were homogenous – that is, they have roughly the same experience which determines the pricing for that particular cluster.

Mr. B. Go noted that there were clusters that have different behaviors. It was explained that if any one exhibited strange behavior, they would be taken out of the cluster. But if the same only consisted of only one event in SME, it would not really lead to a conclusion of termination.

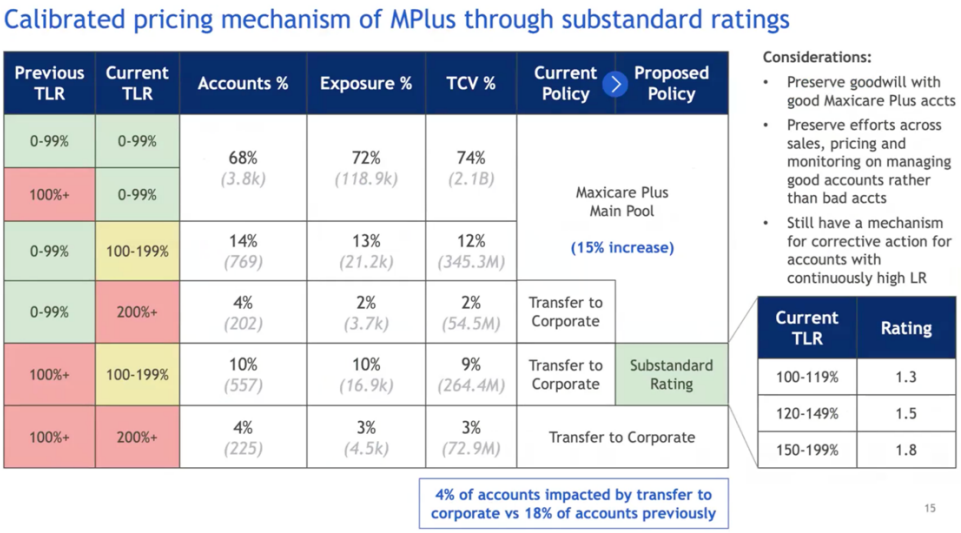
It was clarified that it was just a matter of determining the steady behavior of a particular SME before passing corrective actions in terms of increasing the price significantly or moving them out.

Mr. B. Go inquired whether one hundred (100) was the right number to cut off, because even a two hundred (200)-person account could have high variability.

It was explained that a larger cutoff yielded lesser variabilities. At the same time, however, a cluster should not be very large because the same may end up in a situation where all of the SMEs comprise only of one giant cluster.

Mr. B. Go noted the need for enhancing this technique over time. Mr. Argos commented that grouping/clustering should be done, and that tiering should likewise be made.

It was reported that a two (2)-year window has been taken. In the below group, the first two columns describe the loss ratio of an account over the past 2 years:



The principle to be followed was that if 2 years of consecutively high loss ratios were observed (i.e., 100% and above) corrective action would be applied. Otherwise, those part of the cluster could stay as part of the main pool.

There were 2 kinds of corrective actions:

(1) Application of a substandard rating (i.e., getting 30%, 50% or 80% higher premiums compared to the main pool – based on the loss ratio), or
(2) Transfer to corporate depending on how high the loss ratio was for the running year.

The main thing observed when calibrating the threshold and the corrective actions was to look at how many of the accounts or how many of the members were impacted.

Previously, the policy has been the transfer of 18% of accounts to corporate, effectively generating a natural churn of 18%. The same has been trimmed down to 4%, and that the worst 4% will be transferred to corporate and a relatively significant price increase using the substandard rate would be applied to the succeeding 10%.

Mr. A. Go inquired whether SME remains to be more profitable than corporate. Mr. Argos confirmed that SME was indeed generally more profitable than corporate, and that the gist of the report was that once the cost hit an unfavorable loss ratio, those part of the clustered would be taken out of corporate where the price jumps dramatically. If the longer view would be taken, this could be tolerated at a slightly higher volume for 1 year.

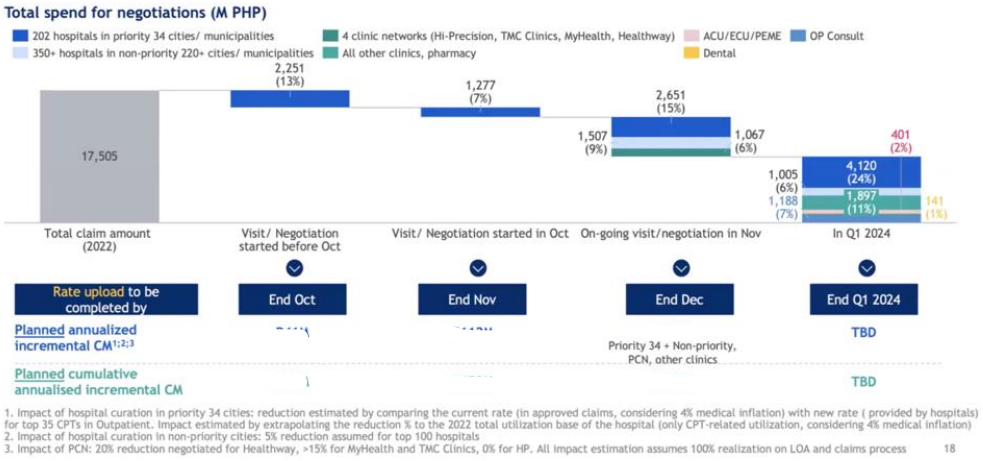
Mr. B. Go clarified that the cut was not based on headcount. Rather, it was based on TLR rates. The 4% would be a worst-case scenario and the very small companies would not go to corporate.

A BCG representative explained that per statistics, typically, when an account with a loss ratio of above 100% on the first year was observed, around half of them could actually go back to being below 100%. Those are the accounts which should not be lost because they could continue to return to a more sustainable utilization.

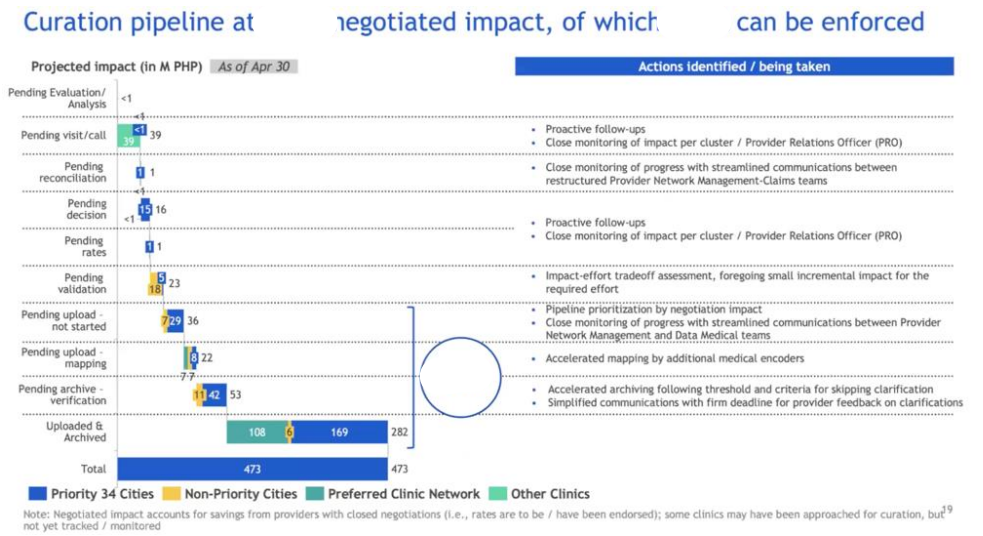
With this, a 2-year window of extension was proposed. It was explained that the hesitation to go beyond 2 years back was because such time covers the pandemic period which had a lot of loss ratios in the industry. The proposal was to look at a steady state.

The intention was to build up the proposal beyond 2 years, so that a study could be done whether it made sense to extend to 3 years.

For IC2, the previous estimate was a [redacted] total impact from the impact center as to hospital and clinic curation:



Currently, [redacted] had been negotiated out of the [redacted]. The pipeline with respect to the [redacted] negotiated impact were as follows:



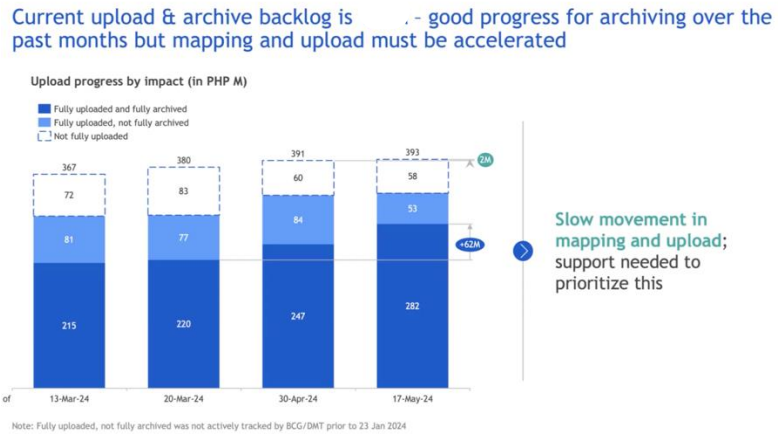
Among the [redacted] that has been successfully secured from the providers, [redacted] worth can be enforced. It was reported that there were big buckets that continue to persist (i.e., pending decisions, validation and verifications on the rates). These big buckets were typically pending or awaiting provider feedback. What has been done so far have already crafted a path to secure the contracts or conformists from these providers who were pending. There were key approaches that have been defined, such as leveraging the different tiers of providers which have been defined.

Mr. B. Go inquired whether HNM was still relying on the augments from JG Procurement or if the same was largely internal. Mr. Argos confirmed that HNM still had support from the Procurement.

Mr. Argos further explained that moving forward the role of Procurement in relation to HNM moving forward had been discussed so that it will be more well-defined and aligned with HNM. Mr. B. Go pointed out that ultimately such in-house capability should be filled out. Mr. Argos discussed that in terms of accountability, the same would always be in-house. As to capability, part of the process had always been to decide whether it was in-house, outsourced, or contracted on a project basis especially the strategic procurement. Depending on the capability, the same could either be in-house, outsourced, or shared services. However, the accountability would always remain with Maxicare.

In terms of rates which are still pending uploads or not yet enforced even though secured from a negotiation standpoint, there were 2 big steps in the process – first one was uploading, and second one was archiving.

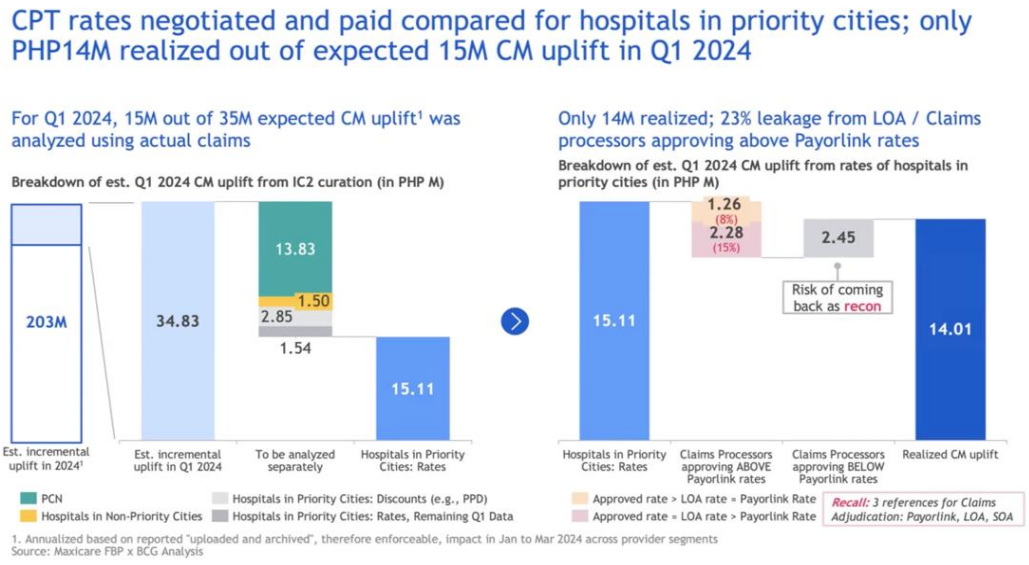
There has been good progress for archiving especially over the past month. However, mapping and uploading must be accelerated as there were slow movements. By way of summary, there was a backlog worth [redacted] annualized impact which was currently being accelerated:



It was reported that an analysis has been conducted to observe how much force of impact was estimated before it was actually realized. The rates that were negotiated for priority cities, specifically in hospitals, have been zeroed in.

For Quarter 1 of 2024, Php15 Million out of Php35 Million CM Uplift was analyzed using actual claims.

Currently, only Php15 Million out of the Php50 Million was realized and its face value was around just 23% of the leakage. In the actual process, as much as 23% was from the LOA processing, which meant that the agents and the claims to processors were being approved above the negotiated rates:



There was also a portion of the impact coming from claims processors approving below what was negotiated or what was uploaded on Payorlink. While this may be good news for now, there is a risk that this value would come back.

Mr. B. Go inquired whether the claims processors were employees. BCG explained that they were mostly outsourced. Mr. Argos answered that there was only one agency which was used for said outsourcing.

Mr. B. Go raised a query as to how their adherence to the correct rates were monitored. Mr. Argos confirmed that various factors were considered and that there was still some leakage, but that the good news was that leakage was very minimal because the big sources of leakages have already been eliminated.

Ms. Go pointed out that ideally, claims should not be allowed to be paid for any amounts that are bigger that what was listed in the LOA. However, there were incomplete set of CPPs, and the Operations Team specifically asked for override capabilities to basically allow any amount. Should the same be turned off, Ms. Go discussed that it was easy to enforce (i.e., in matter of hours, the tight requirement

could be imposed that it must be less or equal). An operational assessment must be made if the CPT rate was not there.

Ms. Go inquired as to their courses of action if the whole thing gets delayed. Mr. Argos explained that there was leakage on both ends of the LOA issuance and claim payments. He noted that the current figures are smaller numbers compared to before because controls of who can override have been provided.

Ms. Fiona Victoria ("Ms. Victoria") confirmed that the front end of the pool of agents would no longer be allowed to manually enroll. They will just make use of drop downs as what was cleaned up by the provider network team.

Normally, what happened was that there may be movements on the CPP rates from the time of LOA issuance and before the claims get processed. When the claims get processed and there was an updated fee, that would be an item for reconciliation.

There may be cases where at the LOA issuances, the CPP rates were not yet available if it was a new modality or test. The agent would have to get the rates from the provider and encode that in the LOA. This would hopefully be cleaned up soon when all the required CPPs per provider have been provided.

Mr. Argos confirmed that all these were being done as linked to ICU as an offshoot. That was why a reduction in the leakage was observed.

Mr. B. Go inquired as to how the resolutions for enforcement and changing of rules were decided. Ms. Victoria explained that different sets of processes were placed (i.e., approval of CPP adjustments). The Operations Team shall handle the use of the CPPs and work instructions because they were basically the users of what the providers team clean up. On the claim side, there was alignment with operations on what CPPs are to be used.

Mr. B. Go inquired whether there were internal audits with respect to the team governing the different functions. Ms. Victoria confirmed that there was a QA team handling the LOA issuance. QA of claims was housed in HNM. There were different sets of data points that must be cleaned up on the claims processing side, and there were different sets of touch points that would have to be cleaned up on the front end.

Mr. B. Go raised that in terms of long-term governance, it would be advisable to have an individual within the organization, who was at the same time independent, to perform an internal check.

Mr. Argos confirmed that such issues are currently being addressed by vendor management and QA for LOA issuance and CPP claims.

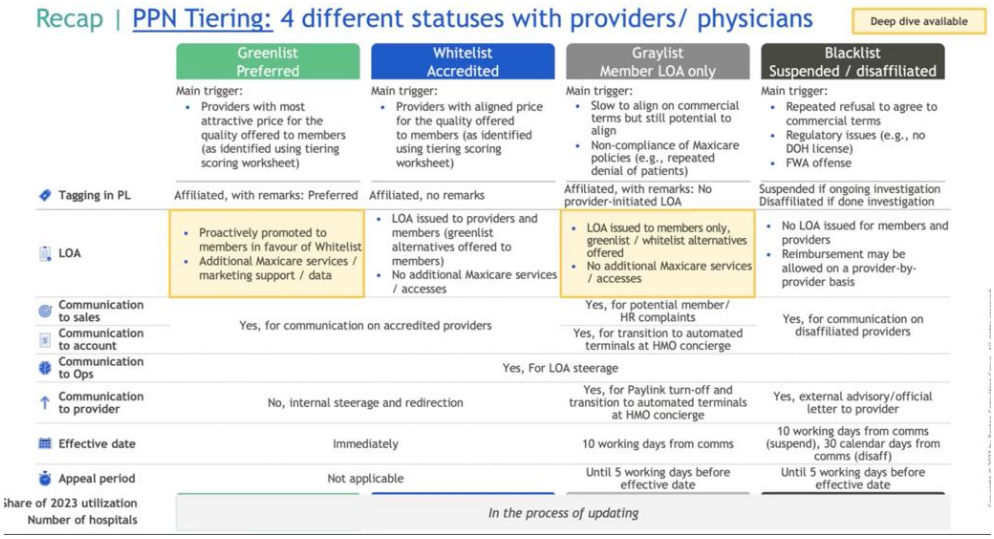
Ms. Go further noted that a consideration must be made as to a platform with respect to the rolling out of access on when the provider was going to change the

rates. There should be a lead time for acceptance by Maxicare and should there be non-acceptance, a steerage on what kind of test was needed must be had for referral to another provider.

It was explained that one of the systems was to make a direct linkage between the provider system and insurance system. In the short term, there would be no problem of inconsistent coding. Every facility has its own different system with different integration.

Ms. Go noted the backlogs by reason of the new modalities which were being allowed, but were not on the list. She further noted the internal issues with the providers. According to her, without a platform, these issues cannot be resolved.

It was further reported that PPN tiering had been categorized into 4 different statuses with providers/physicians:

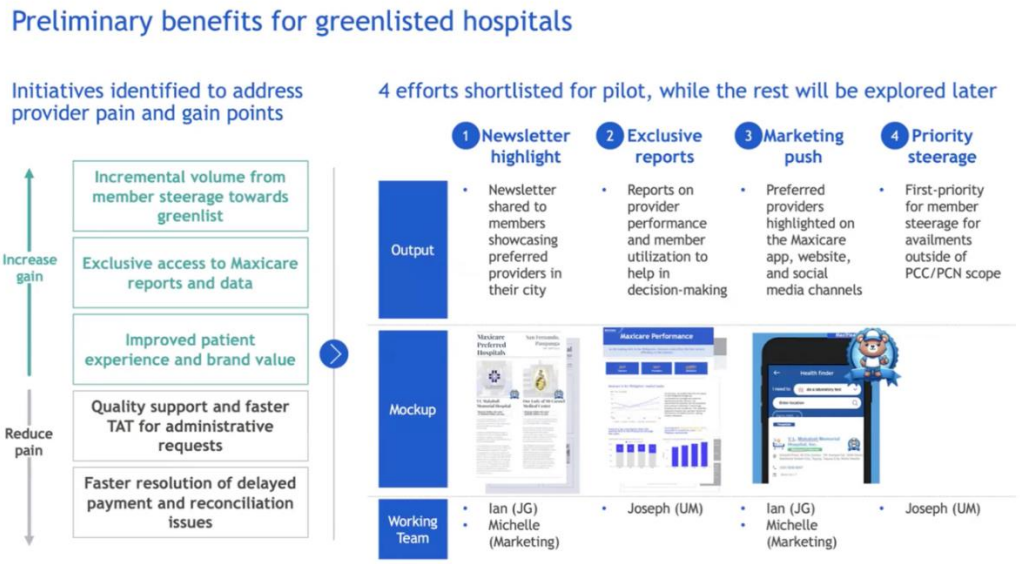


Of the above, the most important where changes were highly observed and where restriction was to be made while keeping them in the network was the green list or preferred providers.

For green lists, they would be kept accredited. The providers would be proactively promoted, and also provide them with additional value aside from volume increases. Such efforts were in the form of marketing push services and exclusive access to data as well.

Mr. B. Go inquired as to the date when the tiering would take effect. It was reported that the pilot was expected to be done before June 2024, and a re-calibration would be done. The target was for implementation to be done by July or August 2024.

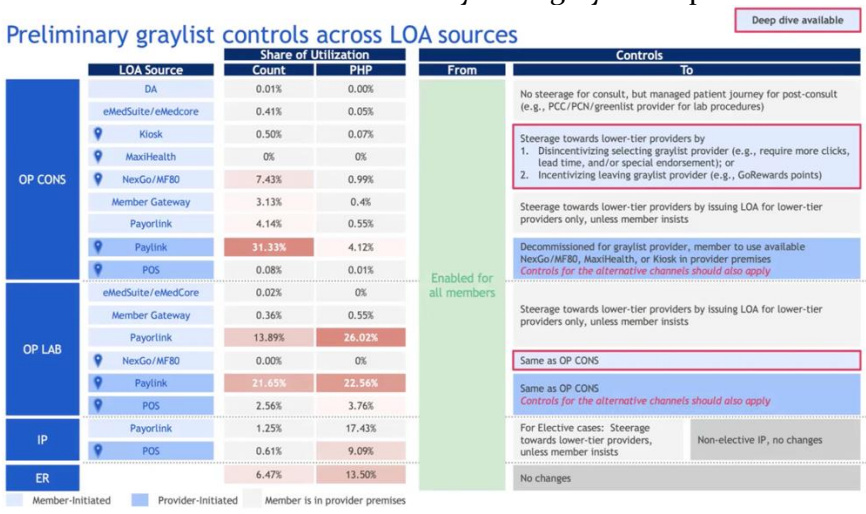
Preliminary benefits for green listed hospitals have been identified for purposes of testing them for reinvested hospitals:



Preferred providers must have value aside from volume. Hence, the gain must be increased and the pain points must be reduced. Initiatives have been identified to address provider pain and gain points. Four (4) efforts have likewise been shortlisted for the pilot cities, to wit:

(1) Newsletter highlight,
(2) Exclusive reports,
(3) Marketing push, and
(4) Priority steerage.

For the gray list providers, efforts have been made to look across LOA sources – different channels where LOAs were released and identifying the difference controls which could be done to steer members away from gray listed providers.



The goals by the next Executive Committee meeting were reported as follows:

(1) For IC1 on Corporate:

a. Continued support on ongoing Q3 renewals

b. Complete enablement of FBP team for corporate pricing

(2) For IC1-B on Consumer/SME:

a. Review pricing of prepaid consumer products

(3) For IC2:

a. Complete uploading and archiving for all rates that have been negotiated as of 01 May 2024

b. Implement process fixes to improve rates enforcement

c. Pilot network tiering measures in select test area/s

d. Develop framework for provider performance review (including scorecard)

ii. Expand PCC Coverage

By way of expansion updates, the following are the new PCCs for the year 2024:

(1) Cubao, QC (Araneta Center) – opened last 30 April 2024
(2) Rizal (Robinson's Metro East) – will be opened on 31 May 2024

For items #3 to #10, everything was on track. The projects would be completed by September 2024.

For item #11, discussions have been made regarding a certain place in Considering that the waiting area could only accommodate six (6) to ten (10) people, the idea was scrapped and the search for a new site was being made.

For item #12, the target date was moved to 30 October 2024 as the lessor turnover could only be done by 15 August 2024.

As of date, the newly opened PCC for Q2 2024 are as follows:

(1) PCC Cubao: soft launch was last 30 April 2024,
(2) PCC Bridgetowne – Expansion: soft launch was last 01 May 2024, and
(3) PCC Metro East: soft launch was last 26 May 2024.

In relation to the PCC studies have been as regards the site location since the area was not yet ready. Two (2) sites ir. were being studied:

(1) and
(2)

With respect to , the site was reported to be very near to the hospitals:

It was reported that the PCC will be a standalone area. If ever the project is pursued, the PCC in said site would be the first standalone PCC.

agreed to construct the PCC and if the signing of the contracts were completed by the month of May 2024, they could start the construction by 01 June 2024. Turnover could then be done by 01 December 2024.

From 01 December 2024, the interiors would have to be completed, and the same could be done by 30 March 2025.

New PCC:

The second site at the Outlets was nine (9) kilometers away from the site. It was nearer to , but was observed to be harder to locate:

The advantages of the site include the fact that the area was already available for construction, and nearer to the area. As to public transport, there were eTrikes, and it was observed that there was no traffic around the area as well.

As to the first criteria on the time to build and operationalize, the financial impact of the five (5)-month delay of the availability of the site were reported as follows:

The recommendation was to push the project site out by January 2025, and reallocate the slot to another site that can be built faster.

There must be a commitment so that the site could be prepared. The interiors would have to be done by January 2025.

It was raised that one of the deliverables was to determine how to man the PCCs that would be opened. The recruitment and training strategy was reported as follows:

The strategy was to be part of the student's education as early as high school. According to the schools it was only MHSI which offers immersion programs for students during their freshman and sophomore years. It was also noted that they have been very active in welcoming OJTs during their junior and senior years. Prior to graduation, the recruitment team would be present in all career fairs. Underboards were hired on the condition that they would take the board examinations within the year.

Partnerships with colleges had been made and said colleges were not owned by hospitals. Tie-ups with review centers had likewise been made as

well as organizations

The different levels of engagement with partner schools were as follows:

Currently, there were 17 partners, and efforts were being made towards more partnerships. The recruitment fairs were conducted as shown below:

After a series of discussions with doctors, the tasks which could be done by a nurse and a non-nurse were agreed upon:

NURSE	**NON-NURSE** ***CUSTOMER CARE REPRESENTATIVE ("CCR")***
(1) Administering injections (vaccines) (2) Dispensing drugs (3) First aid (4) Administration of the Treadmill stress test	(1) ECG (2) Vital Signs (3) Sterilization and storage of equipment (4) Decking & queueing patients (5) Securing consent for administration of vaccines

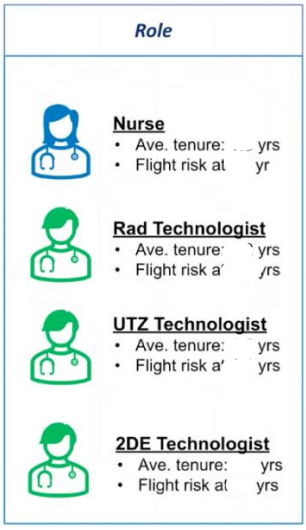
	(6) Updates medical records on daily consultations (7) Attends to patient concerns and inquiries in the clinic (8) Sending of results to members (9) Responds to patients' email inquiries

As to the workforce, there have been shifting manpower ratios in the PCCs. The current plantilla requirements had a 10:4 nurse/CCR ratio with 10 nurses per PCC manning 4 pax/hour, and 4 CCRs per PCC manning 1-2 pax/hour.

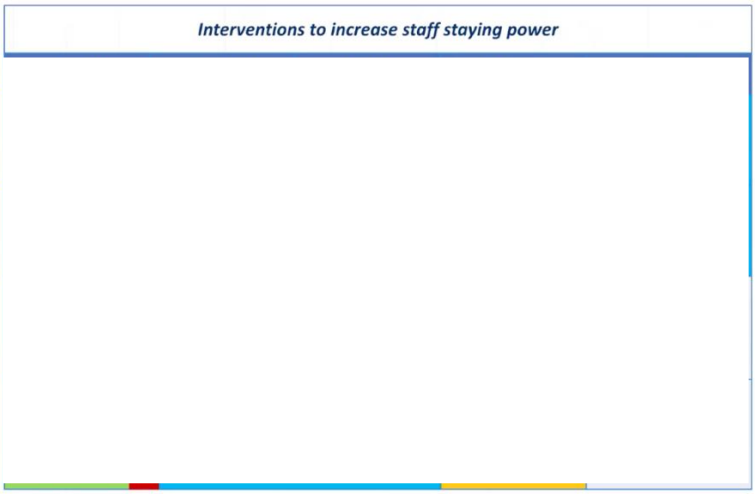
The new plantilla requirements would be : nurse/CCR ratio with nurses per PCC manning pax/hour, and CCRs per PCC manning pax/hour:

Mr. B. Go inquired as to what were the requirements for a CCR. It was reported that a CCR should be from the medical field (i.e., psychology graduate) and individuals with good interpersonal skills.

According to records, the average tenure of all active nurses (around 400) was years.



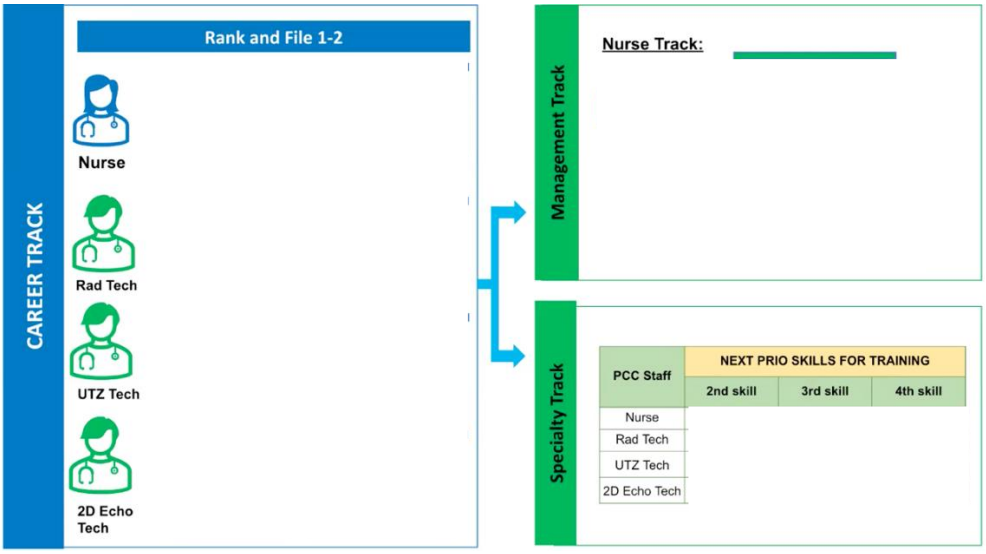
For higher retention of personnel, early intervention and career pathing were endeavored. Interventions to increase staff staying powers were reported as follows:



As to the resigning nurses, the tenure was typically years. Hence, the flight risk of nurses in MHSI would be on the year. Should they pass the year, they were most likely to stay beyonc years. Intervention must already be enforced by the year for nurses.

For radio technologists, the flight risk was at years; for UTZ technologists - years; for 2DE Technologists - ears.

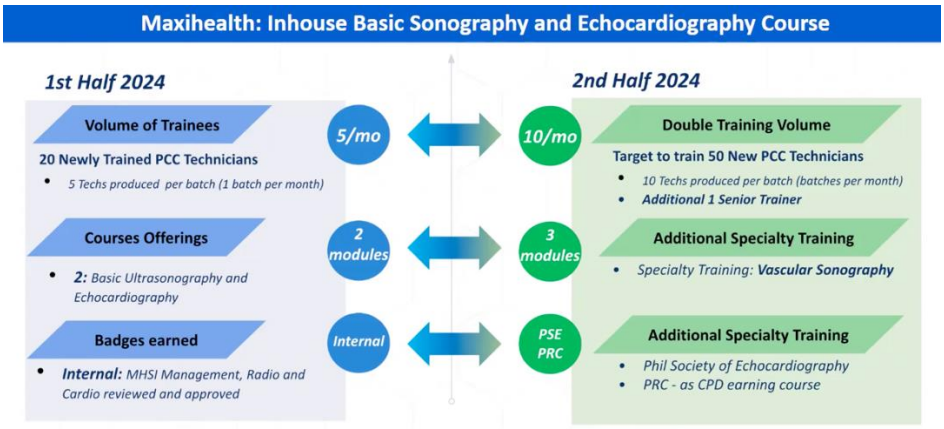
The training which nurses and radio technologists could look forward to were reported as follows:



The technical positions were classified into 2 and specialty training would be offered.

Another senior trainer would have to be onboarded. For the first quarter of the year, more than 50 nurses and radio technologists have already been trained.

It was further reported that training was modified to make the technical trainees PRC[9]-recognized.



iii. Maxigroup Insurance System and Top IT Initiatives

The Chief Technology Officer, Mr. Nedino Cayetano ("Mr. Cayetano"), discussed that since the start of January 2024, fourteen (14) out of the sixty-two (62) listed initiatives were already completed. Eighteen (18) were eliminated after the approval of the MIS[10] core system last 29 April 2024, thus retaining only thirty (30) initiatives to date.

According to Mr. Cayetano, fifteen (15) out of thirty (30) initiatives were going to be prioritized, as these projects would have the most impact to the organization. He will later discuss in detail the top 15 initiatives.

The Maxigroup MIS Project Team and Procurement Team were both waiting for response to all items or non-negotiables. Mr. Cayetano noted, however, that the solutions confirmation had already commenced for Maxilife last 15 May 2024 so that more time could be allotted for the preparation of all legal documents pertinent to the items / non-negotiables.

The new Maxigroup ecosystem architecture was already made as pre-work prior the Maxigroup blueprinting session which was expected to start right after the completion of procurement negotiations.

Further, the Program was on track. This included the member portal, unified scheduling system and eMedcore+.

[9] PRC: Professional Regulation Commission
[10] MIS: Maxicare Insurance System

Mr. Cavetano further discussed that the [redacted] Program was on track. This included both enterprise SO and eKYC initiatives. According to Mr. Cayetano, the eKYC use cases have been consolidated already and the recommendation would be presented to formally officialize the eKYC projectization.

Mr. Cayetano added that the [redacted] was on track. Video integration was done, and the internal launch was conducted last 15 April 2024. The SFDC Signature Success Team presented the revamped agent tool user interface, and internal teams were working to implement this on our own SFDC sandbox / servers.

HNM had transitioned their current powerBI reports from having been connected to Payorlink to the centralized report server owned by Maxicare. Finishing touches were being made to the centralized report server which were expected to be completed by 24 May 2024.

The timeline of the MIS Program was presented as follows:

Reviews of the master agreement with [redacted], order documents and fixed price documents were currently being made. Although there were still documents that were yet to be given, the project was still on track since the launch of the MaxiLife solutions confirmation would be held on 29 May 2024. By 03 June 2024, the solutions confirmation for Maxicare would commence. By the end of June 2024, it was expected that everything related to solutions confirmation have been completed already. Hence, by July, the implementation proper can start.

Mr. Cayetano explained that the months of July, August and September 2024 would be spent on setting up and configuration of core insurance system instances for both Maxicare and MaxiLife with respect to the server, as well as the products and services.

This would be implemented end-to-end up to the claims side by September 2024.

In relation to the Maxigroup Priority Initiatives, Mr. Cayetano reported that all of the unique issues for PL1[11], PL2[12], ACVP and SAP have already been resolved buring the month of May.

The rest of the programs were still ongoing with their respective target dates reported as follows:

[11] PL1: Payorlink 1
[12] PL2: Payorlink 2

Priority	Maxigroup Initiative Name	Project Manager Assigned	Maxigroup Point of Contact(s)	Maxigroup Project Sponsor(s)	RAG Status	Production Timeline
1	PL1 / PL2 / ACVP / SAP Unique Issues Resolution	Ned Cayetano (Maxicare)	Ned Cayetano	Ned Cayetano	Completed	May 2024
2					Ongoing Solutions Confirmation	
3					Ongoing Solutions Confirmation	
4					Ongoing	
5					Ongoing	
6					Ongoing	
7					Ongoing	
8					Ongoing	
9					Ongoing	

Mr. Cayetano dubbed as a program since there was already an eKYC element already aside from Enterprise SSO and Identity Access Management. The would be the single source as everything related to contact number, email address and anything needed to reach the members should be found there.

The other projects, along with their production timelines were reported as follows:

Priority	Maxigroup Initiative Name	Project Manager Assigned	Maxigroup Point of Contact(s)	Maxigroup Project Sponsor(s)	RAG Status	Production Timeline
10					Ongoing	
11					Ongoing	
12					Ongoing	
13					Ongoing	
14					Ongoing	
15					Ongoing	
16					Ongoing	

Mr. Cayetano pointed out that the common denominator of the production timelines of these projects would all end by . The plan was to finish all of these projects by and zero them out by the end of this year.

Mr. A. Go raised a query as regards the timeline for the dental clinic project. Ms. Go noted that an application was needed for the dental clinic. Ms. Go further discussed that nobody was signed up to do the front-end and that the back-end was used by the agents.

[13] CIAM: Customer Identify and Access Management

It was reported that there were initial discussions on automating dental LOAs. The plan was to align it with a semi-dental program. The dependency was that they do not have CPPs for dental that can be used for automation.

Ms. Victoria explained that Mr. Cayetano discussed the end-to-end automation from the dental clinic, requesting the approval to an agent approving the request. The problem currently being resolved was the Php2 Million cost for dental processing.

Ms. Victoria clarified that the dental clinic would retain its process of requesting approval, but the annual claims processing from the claim side would have to be eliminated by having the auto approval based on the number and dental procedure.

Mr. A. Go requested for the timeline as to when the . per month savings would be generated. Mr. B. Go additionally inquired whether said savings would be generated concurrently with the MIS project, or after the same.

Mr. Argos noted that the most efficient course of action was to incorporate the dental project to the standard benefits. This would allow for consistency among the hospitals, clinics and dental clinics. Hence, automation can be done on the same pipeline.

He further explained that the dental benefits have a completely different benefit structure. Thus, the dental benefits must be joined together with the standard benefits. Since all automation would be applied to the standards benefits, there was still a need for specific dental approval.

Mr. B. Go suggested to have the timeline regarding the dental project in the overall roadmap. Mr. Argos further suggested to include the dental project as a specific item in the initiatives. In the event that the dental project was aimed to be included as part of MHSI, such fact should be specifically laid out because the project must be aligned with all automation process.

Mr. B. Go raised a query as regards the date when the product roadmap would be presented before the Executive Committee.

Mr. Argos explained that the product roadmap should be presented by the third Quarter. Ms. Victoria further clarified that based on the OGS first presented before the Executive Committee for the Ready Now products, the second wave would be the 6^{th} to 12^{th} month products.

It was clarified that in this Executive Committee meeting, there was no product presentation.

The Committee members remarked that they are looking forward to the product development session.

Mr. Michael P. Liwanag ("Mr. Liwanag") added that he reached out to Mr. Kurleigh Gacutan ("Mr. Gacutan") in relation to the product development process. He noted that Mr. Gacutan's Team was trying to adopt a similar process to that of URC[14]. He suggested that it may be good to have a product presentation to the Committee monthly or every other month so that they would be apprised of what products would be launched within a given timeframe. It would likewise be good to have that business team cross-functional discipline in developing products to aid in efficiency.

Ms. Victoria discussed that presentations would be made regarding the products to be launched.

Ms. Go raised that the first new products would be the

Ms. Go discussed that the bill system configuration would begin on 10 June 2024. She inquired as to its features and target market. She raised the need of it being presented at the cadence meetings to avoid the risk of surprises considering that building would start in June 2024. Before the configuration started on 10 June 2024, she raised the importance of understanding what was to be configured and its features.

Mr. Argos recommended to identify the stage when the same would be elevated to the Executive Committee for visibility and consistency. Every single product across all categories should have Executive Committee visibility and a refresh on the roadmap. In the next Executive Committee meeting, visibility on the most up to date version of the roadmap across the three entities would be given.

Mr. B. Go noted that two things must be done:

(1) For the Executive Committee, to regularly update on the progress and status of the product roadmap which include launches and monitoring of products; and
(2) There must be a process of funneling and resourcing.

[14] URC: Universal Robina Corporation.

Mr. Liwanag recalled the discussion on B2C Products and the fact that they were prone to abuse. He suggested to look into the controls and risk management of the products such that there would be no leakages of possible abuse from customers.

Financial Report

The financial report on the April 2024 Financial Statements was reported by Ms. Teresita Espallardo ("Ms. Espallardo") as follows:

April 2024 Income Statement - FOR THE MONTH

Net Income for the Month - Php43.73M

- **vs F1 Net Loss of Php 83.43M -** Better by Php 127.15M or 152.41% attributable to favorable variances in:
  - Net revenue of Php 54.24M
  - Total Direct cost of Php 47.43M
  - Total Indirect cost of Php 54.42M
  - Other Income of Php 10.53M
- **vs Budget Net Income of P50.57M** – lower by Php 6.85M or 13.54% attributed to unfavorable variances vs the budget in Net Revenue by 95M but mostly offset by the following favorable variances:
  - Total Direct Cost by Php 24.09M
  - Total Indirect Cost by Php 43M
  - Other Income by Php 15.9M
- **vs April 2023 net income of P60.13M**– lower by Php 16.41M or 27.28% vs April 2023 net loss due to unfavorable variances in:
  - Total Direct cost by Php 259.48M
  - Total Indirect cost by Php 18.15M
  - Above Items were partly offset by favorable variance in Net Revenue by Php 237.4M and other income by Php 14M

April 2024 Income Statement - YEAR-TO-DATE

Net Income YTD April 2024 - P53.55M

- **vs Budget of P138.95M net loss–** P192.50M or 138.54% better than the budget due to the favorable variances in:
  - Total Direct Cost by P354.69M;
  - Total Indirect Cost by P162.66M
  - Other Income by P52.43M
  - Above exceeds the P318.78M shortfall vs budget in Net Revenue.
- vs **YTD April 2023 net loss P168.93M**– Better results by P222.48M or 131.7% due to favorable variances in
  - Net Revenue by P949.34M
  - Other Income by P53.81M
  - Above exceeds unfavorable variances in Total Direct Cost and Total Indirect Expenses of P714.01M.

Balance Sheet as of April 2024

- **Total Assets increased by PhP3.48B or 20.59% from December 31, 2023 (Audited)**
  - Php 1.6B increase in Cash and Cash Equivalents
  - Php 1.58B increase in Trade and Other Receivables
- **Total Liabilities increased by PhP3.42B from December 31, 2023 (Audited)** mainly from Healthcare Plan Liabilities by Php 2.94B.

Key Performance Ratios for April 2024

- **Net Worth** is at **P1.90B as of April 30, 2024,** more than the Paid-up capital (net worth requirement) of 1.85B.
- **ATR (Acid Test Ratio) -** .947 (compliant to the 0.75 (temporary) minimum requirement)

April 2024 ended with a Php43.73 Million Net Income which was opposite of what was forecasted presented at the April Executive Committee of a net loss of

All major sections resulted in favorable variance.

For net revenue, ASO income drove the positive variance. The total direct cost was likewise lower by Php42 Million. PCC was also lower by Php22 Million while teleconsult was lower by Php8 Million.

For the Operating Expenses, there was a favorable variance in the total indirect cost of Php54.4 Million, but Php29.9 Million of this would be spent this year.

If the savings would not be included, the Php43 Million net income should have been just Php8 Million because Php29 Million was Operating Expenses savings or deferred expenses. There was likewise a Php18Million which would accrue for complete billing by the month of June 2024. These may, however, be highly disputed by the client because these were 2023 to February 2024 claims or availments in the PCC catch up billing which were either not part of the benefits or were out of period.

What was projected was from a forecast of Php108Million net loss, a lower net loss of around Php43 Million was forecasted because of certain adjustments.

The normal course of business (i.e., cash) were the items that moved the balance sheet. An increase of Php1.6 Billion cash was reported due to higher collections, pre-receivables, and health care plan liabilities.

Compliance was reported to have been maintained for the IC regulatory requirement for net worth and asset ratio.

Maxicare received a Bureau of Internal Revenue ("BIR") Letter of Authority ("LOA") for Taxable Year 2022 to examine the books of accounts and other accounting records for ALL INTERNAL REVENUE TAXES for the period from 01 January 2022 to 31 December 2022 except VALUE ADDED TAXES. It was received last 15 May 2024 with documents needed to be provided on or before 25 May 2024 (within 10 days).

With the endorsement of Mancom, a proposal was suggested to get the Executive Committee's approval to engage CPFN to handle the tax matters, specifically the LOA. It was reported that CPFN has been handling the tax assessments with the BIR.

The engagement fee of CPFN was priced at the amount of Php500,000.00.

In this regard, an action item was raised for the Finance Team to perform an analysis of the tax exposure for the Year 2022.

Ms. Go raised the additional work for the internal audit to track. Mr. Argos clarified that an executive session must be held in relation to the exposure on the unofficial receipts. The findings must be refreshed in light of the current state of findings.

It was clarified that even the vendors were affected by the EOPT[15]. VAT remittance would already be on an accrual basis documentation-wise. If the services involved a long-term contract (i.e., 1 year or more), there would be a monthly invoice released / issued pertaining to the earned portion of the revenue. Vendors must pay in advance their taxes.

It was raised by Ms. Espallardo that one of the plans of action was to develop an invoicing program in SAP to comply with the monthly invoicing requirement. Mr. Argos explained that such course of action was still subject to alignment.

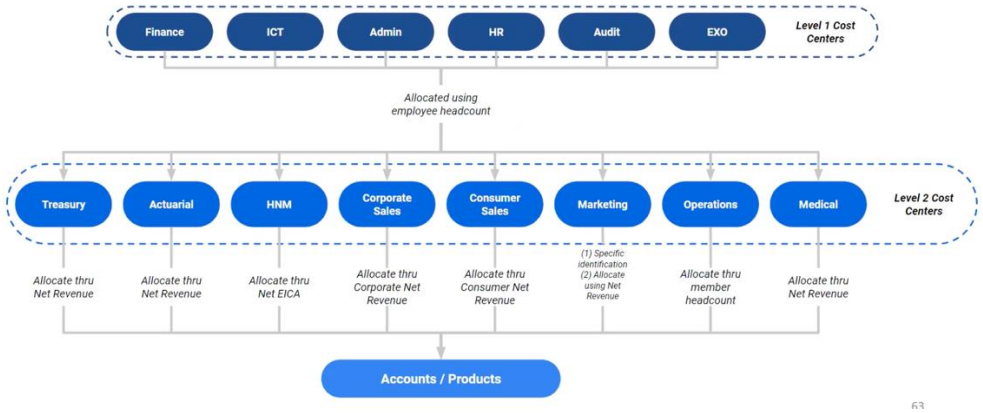
The updates on the preparations for the profitability report were reported by Mr. Macapagat ("Mr. Macapagat") as follows:

P&L Component	CORPORATE		CONSUMER		
	FR	ASO	SME	IFG	PC
Net Revenue	Data captured as posted in ERP; mapped by GL accounts				
EICA	Per Actuarial Report	N/A	Per Actuarial Report		
Rider	Allocate cost using the list of products with applicable riders with the complete rider headcount from the active member headcount report				
PCC Cost	Actual MHSI billings attributed to Corporate & Consumer products based on actual availments obtained from the PCN dashboard overview.				
Enrollment and Processing	Allocated based on LOA count and enrollment fulfillment & member headcount.				
OPEX	***Allocation steps shown in next slide***				
Indirect Member and LOA Costs	Allocated based on LOA count and enrollment fulfillment and member headcount				
Indirect UM Initiatives	Corp-FR only	–	–	–	–
Other Net Income, net	Allocated based on EICA and Net Revenue				
Provision for Income Tax	Income (Loss) before Tax multiplied by the effective tax rate.				
Net Income	Income or loss after deducting all costs and taxes.				

Generally, this was how the flow of profits were allocated. The P&L Component approached a more granular split specifically on the Operating Expenses (OPEX) portion.

The OPEX Line, which was a big portion of the P&L Component, needed more specific attention. A line of allocation for OPEX was developed, with basically two (2) classifications for cost centers:

[15] EOPT: Ease of Paying Taxes



There are current activities to bring this down lower by one level – to the departments. There was cost center allocation to other cost centers, and there are other cost centers being allocated to other accounts and products.

The same approach would be implemented, especially in relation to the exploration of the P&L.

Mr. B. Go expressed his curiosity on the industry-specific standard practices as regards allocation for HMOs. In this regard, Mr. A. Go suggested to determine how to allocate the profits in terms of incremental cost. Mr. B. Go further suggested if could share information on how they do the allocation for large HMOs (i.e., in the United States). Mr. Argos confirmed that they could ask for such information from Fusion.

Mr. Macapagat continued to report that the plan was to have some of the work done into translating the PCC cost into the variable and fixed component (i.e., PCC Variable Costs and PCC Fixed Costs):

Mr. A. Go inquired whether it was possible to predict the projection of the less direct costs whenever there was movement in the member portal (i.e., the sooner the move to the member portal, the sooner there are savings).

Mr. Argos suggested to curate a scenario modeling where it would be shown that a decrease in cost could happen if one achieved a specific metric.

Ms. Go raised a query as to when the first set of profitability reports were expected to be produced. It was reported that the first set would be the budget for 2025 and would be done by that time.

Mr. B. Go questioned the report on "other income: modal factor" – he inquired whether the report could treat other income and modal factor. It was explained that the "other income: modal factor" was an alternative view, similar to how other businesses were viewed as cash basis.

As regards the actuarial report, the following points were raised by Mr. Jasper Cheng ("Mr. Cheng"):

(1) Medical Loss Ratio (MLR)
(2) Membership Fee (MF) and CM per Capita (Pricing cohort basis)
(3) Pricing Accuracy – Deviation of estimated MUC starting October 2023

Firstly, there was a continued reduction to the Medical Loss Ratio and Total Loss Ratio for years 2022, 2023 and 2024.

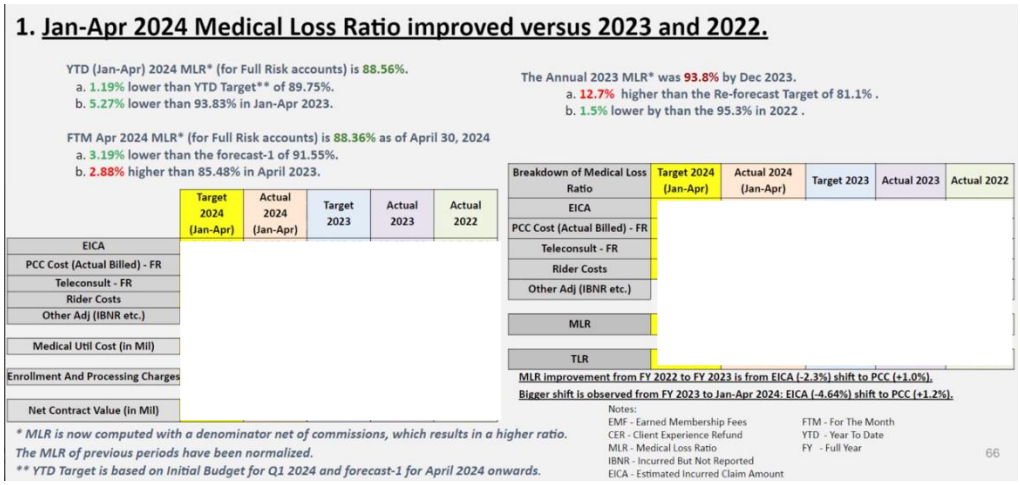
The 88.56% MLR recorded was in line with the plan or forecast. In terms of PCC Cost and teleconsult, the goal was to have more steerage. It was reported that they have been on track up to April 2024.

As to the point on reconciliation, a row on TLR[16] (92.28%) was added. This actually reconciles directly with the report of Finance.

If ASO was removed from both income and expense, it would be 90.89%.

It was reported that the contribution market was 100% less the TLR. For January to April 2024 the MLR[17] improved as compared with years 2023 and 2022:

[16] TLR: Total Loss Ratio
[17] MLR: Medical Loss Ratio



As to the second point, the membership fees increased during years 2023 and 2024, driven by a higher target CM%.

e in CM, as previously reported, were in line with the ngures in the below chart:

For the whole year, the percentage was not just at 11% but actually 13%.

Second, the estimates when the actual CM will land have been continuously monitored and updated.

For 2023, it was previously reported that the percentage would reach at around 11.3%. Now, the percentage reached 11.1%, primarily because there was worse experience from the accounts like Accenture which had higher utilization last year.

The data shows that 2024 was falling behind, but this was because of the recognition on dental. Previously, what was only recorded was the actual cost of dental, which was cheaper than the capitated fee already guaranteed that would

be paid to providers, recognizing that it would actually place the percentage closer to the price.

Mr. A. Go inquired whether they were making money on the dental rider. It was confirmed that they were, with the qualification that they could make more in theory if they did the dental procedures themselves.

Mr. Argos explained that the compensation which were given to the dental clinics were not even enough to cover the cost of giving. The business model was that a market was given for upselling, and money was made on the upsell.

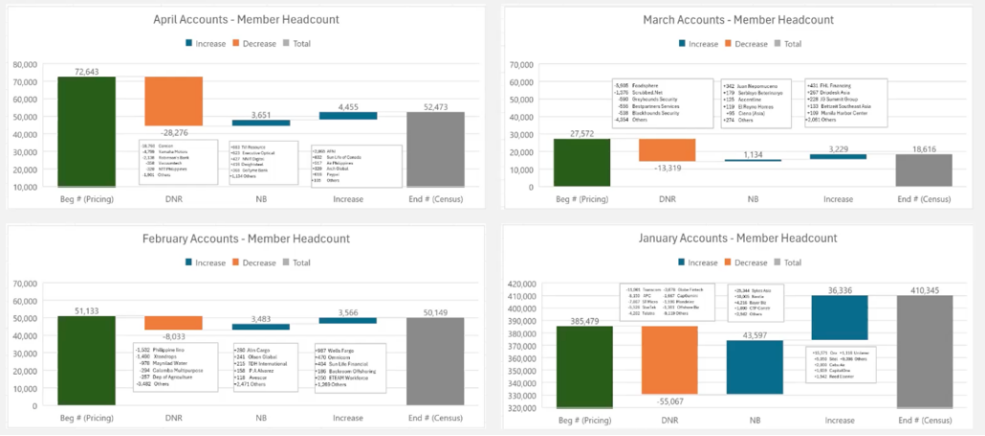
Mr. Argos raised the action item of revisiting the dental as a rider and to see if the entire business model needs to be changed (i.e., restructure the way it was priced and reconstruction of the compensation of dentists).

Mr. Argos further discussed the topic of whether the conversation as regards the PCCs should be considered for dental clinics – but only basic services would be offered and everything would be referred out. Mr. Argos noted, however, that they were not currently ready to consider such option.

It was reported that even with the utilization being updated, the trend for actual CM was still a sharp improvement compared to previous years.

In the previous reports, all full risk for corporate and consumer were shown. In the current report, all full risk for corporate was likewise reported – one is to one from the previous to the renewing year. There was a good comparison whether the MF actually increased or not.

The summary on bridging was reported as follows:

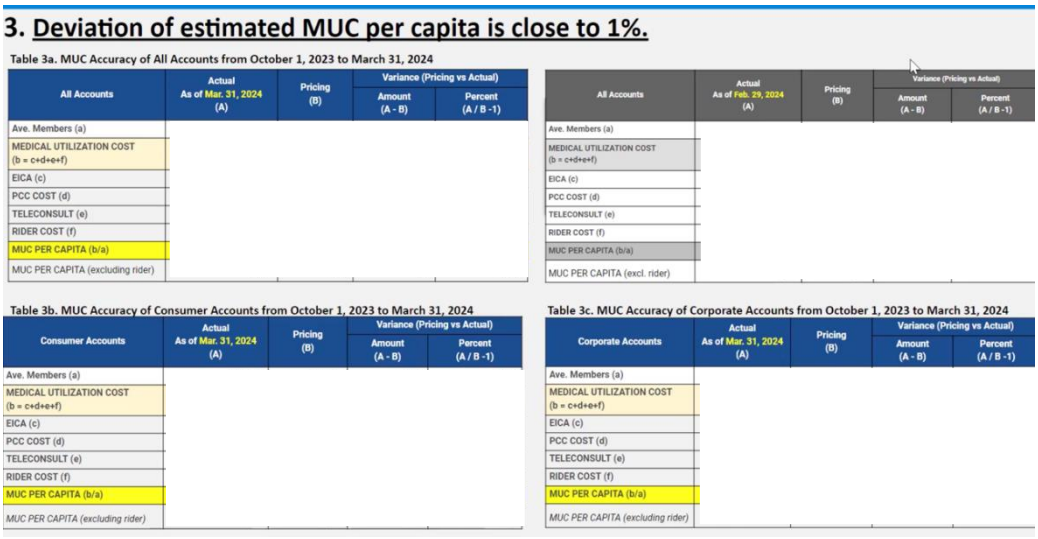


Generally, there were a lot of DNRs but it was offset by new business and growth in the key accounts – hence the jump in the headcount from January 2023 to January 2024. For April, there was bigger drop in DNR because of two key

accounts:

were high loss ratio businesses, hence they were given up.

On the pricing accuracy, it was reported that a lower 4% (-4%) pricing accuracy was shown. From this 4%, 2% was from the dental where only the actual cost was shown, not the capitated fee. The actual cost was understated because it did not include the administration costs.



3. Deviation of estimated MUC per capita is close to 1%.

Table 3a. MUC Accuracy of All Accounts from October 1, 2023 to March 31, 2024

All Accounts	Actual As of Mar. 31, 2024 (A)	Pricing (B)	Variance (Pricing vs Actual) Amount (A - B)	Variance (Pricing vs Actual) Percent (A / B -1)
Ave. Members (a)				
MEDICAL UTILIZATION COST (b = c+d+e+f)				
EICA (c)				
PCC COST (d)				
TELECONSULT (e)				
RIDER COST (f)				
MUC PER CAPITA (b/a)				
MUC PER CAPITA (excluding rider)				

All Accounts	Actual As of Feb. 29, 2024 (A)	Pricing (B)	Variance (Pricing vs Actual) Amount (A - B)	Variance (Pricing vs Actual) Percent (A / B -1)
Ave. Members (a)				
MEDICAL UTILIZATION COST (b = c+d+e+f)				
EICA (c)				
PCC COST (d)				
TELECONSULT (e)				
RIDER COST (f)				
MUC PER CAPITA (b/a)				
MUC PER CAPITA (excl. rider)				

Table 3b. MUC Accuracy of Consumer Accounts from October 1, 2023 to March 31, 2024

Consumer Accounts	Actual As of Mar. 31, 2024 (A)	Pricing (B)	Variance (Pricing vs Actual) Amount (A - B)	Variance (Pricing vs Actual) Percent (A / B -1)
Ave. Members (a)				
MEDICAL UTILIZATION COST (b = c+d+e+f)				
EICA (c)				
PCC COST (d)				
TELECONSULT (e)				
RIDER COST (f)				
MUC PER CAPITA (b/a)				
MUC PER CAPITA (excluding rider)				

Table 3c. MUC Accuracy of Corporate Accounts from October 1, 2023 to March 31, 2024

Corporate Accounts	Actual As of Mar. 31, 2024 (A)	Pricing (B)	Variance (Pricing vs Actual) Amount (A - B)	Variance (Pricing vs Actual) Percent (A / B -1)
Ave. Members (a)				
MEDICAL UTILIZATION COST (b = c+d+e+f)				
EICA (c)				
PCC COST (d)				
TELECONSULT (e)				
RIDER COST (f)				
MUC PER CAPITA (b/a)				
MUC PER CAPITA (excluding rider)				

The dental did not really change the variance. The deviation of estimated MUC per capita was close to 1%. The pricing was more conservative than actual by around 1%.

The level of enterprising by the type of MUC was also observed. In terms of PCC Costing, there was bigger subsidy for ACA and PCC was underpriced. Such underpricing has been recognized early this year, and was being built into the new pricing.

The aim was to balance ACA and PCC where the ECC underpricing would decrease while the ACA overpricing would decrease as well.

Overall, it was clarified that the status of -1% was okay, but it had to be ensured that exposure to an uneven balance of products was avoided.

iv. Corporate Sales Report

The Corporate Sales Report for the months of January to April 2024 were reported as follows:

- Corporate Sales Performance
  - 102.37% achievement
  - 14.64% growth from 2023
- Corporate Gain & Loss
  - Highest Gain *Etiqa at 404 M*
  - Highest Loss *Intellicare at 408 M*
  - Highest Net Gain *Etiqa at 382 M*
  - Highest Net Loss *Cocolife at 251 M*
    - *ICare at 388 M (0 Gains)*

	2024 Actual Performance (M)	2023 Actual Performance (M)	% Growth	Php Growth (M)	2024 Actual Target	% Performance
NEW BUSINESS (NB)	866	877	-1.25%	-11	600	144.33%
RENEWAL BUSINESS (RB)						
RENEWED	11,018	9,489	16.11%	1,529	11,009	100.08%
DNR	1,814	1,255	44.54%	559		16.48%
TOTAL NB AND RB	11,884	10,366	14.64%	1,518	11,609	102.37%

The team achieved 102.37% of its target for January to April 2024 with 14.64% growth from 2023 for business and corporate combined.

However, there was a 1% decline from the performance of new business as compared to last year, but the 144.33% achievement in terms of the Year to Date target.

For renewable business, while there was a significant DNR TCD loss for January to April 2024 amounting to Php1.8 Billion, the renewal business was able to grow by 60% and 100% achievement of its annual Year to Date target.

For total new business and renewal business, Php11.8 Billion worth of closed and renewed accounts have been achieved, compared with its target of Php11.6 Billion – hence the performance of 102.37%.

The trend of increasing iCare losses was likewise reported as the losses or nonrenewable transferring to iCare were being monitored, the biggest one of which was

. was a client which shifted to iCare last 01 April. The proposal was at 29% increase, while iCare only offered 7% from status quo. The margin was at a Php60 Million difference and the quoted loss ratio of iCare was at 95%, but it actually ended more than 100% based on the updated loss ratio.

Mr. Lance Gokongwei ("Mr. Gokongwei") inquired whether iCare had a PCC. It was confirmed that it had none. Their offer of a Php60 million discount was also inclusive of the retainer personnel which was posted in the 29%.

It was further discussed that their ties with lasted for 6 years. Mr. Gokongwei questioned whether . has a good experience with iCare.

The scenario with was the same experience for two (2) other accounts which shifted to iCare earlier this year. The first wa , a long time client of Maxicare as well. The quote was a 20% to 30% increase and the offer was status quo.

The first 2 clients were already having issues on availment.

New Business Jan - Apr 2024			
Particular	**2024 Actual**	**2023 Actual**	**% Growth**
Number of New Accounts			
Number of New Members of New Accounts			
Estimated Total Contract Value (TCV)			
Estimated premium per capita			

Renewal Business Jan - Apr 2024			
Particular	**2024 Actual**	**2023 Actual**	**% Growth**
Number of Renewed Accounts			
Number of Renewed Members			
Estimated Total Contract Value (TCV)			
Estimated premium per capita			

DNR Jan - Apr 2024			
Particular	**2024 Actual**	**2023 Actual**	**% Growth**
Number of DNR Accounts			
Number of DNR Members			
Estimated Total Contract Value (TCV)			
Estimated premium per capita			

For the new business, the 82 new accounts have been transitioned from January to April 2024, 14 of which were for the month of May 2024.

It was a 64% growth in terms of the number of accounts, but was a decline in terms of headcount. There were lesser members for the accounts closed this 2024, although the premium per capita proposed to the new business, which on an average was not a 26% CM for all new accounts, the premium per capita also increased by 46%.

For renewal business, there was also a decline in terms of the number of renewed accounts by 14%.

There was a decline of the sites closed for some BPOs. For ., there was a major decline on the voluntary program which were paid for by the employees – dependents program.

The voluntary plan was a separate contract and there was a 90% decline in terms of headcount for

For the premium per capita for renewal business, it was actually a 35% growth from the closing premium per capita same period of last year.

For the DNR, there was a total of 107 number of renewed accounts. with 14 of those for the month of April – the biggest of which were The premium per capita offers for these accounts was 13,000 which was very low compared to the existing per capita renewed at 18,000. The loss ratio for these accounts range from 95% to 115%.

For new accounts, two additional accounts were reported. Below were the accounts with 5 Million and above TCV:

EFFECTIVE DATE	ACCOUNT NAME	TCV (M)	Headcount	Previous Provider	CM	REASON FOR CLOSING
1-Jan-24		380	13,909		3%	
14-Jan-24		136	4,188		23%	
1-Jan-24		34	1,251		23%	
1-Jan-24		14	1,120		9%	
25-Jan-24		11	1,010		25%	
1-Jan-24		6	250		25%	
1-Jan-24		5	191		23%	
1-Jan-24		5	445		25%	
6-Feb-24		8	283		27%	
1-Feb-24		7	296		25%	
7-Feb-24		6	264		25%	
3-Feb-24		5	168		27%	
28-Feb-24		16	896		22%	
5-Mar-24		16	423		25%	
1-Mar-24		11	400		25%	
1-Mar-24		7	240		25%	
1-Mar-24		6	514		18%	
30-Mar-24		6	307		25%	
1-Mar-24		5	429		21%	
15-Apr-24		8	570		27%	
1-Apr-24		7	358		25%	
1-Mar-24		39	2,427		8.63% (ASO)	

have already been transitioned, and the fair price was based on the pricing requirements for new business.

For renewed accounts, the below were those with TCV of 10 Million and above:

EFFECTIVE DATE	ACCOUNT NAME	ENDING LR	ENDING CM	INCREASE	NEW CM	2024 TCV WITHOUT VAT	HEADCOUNT
04/01/2024		105.93%	-10.17%	52.00%	16.00%	232,436,071.00	6,605
04/01/2024		92.61%	3.69%	30.00%	17.26%	219,498,977.00	12,368
04/01/2024		89.43%	6.99%	21.00%	15.00%	115,715,069.02	2,995
04/16/2024		112.75%	-17.82%	50.00%	14.33%	114,125,182.00	4,655
04/01/2024		87.00%	9.52%	20.00%	18.97%	94,328,498.21	3,413
04/01/2024		74.16%	22.87%	20.00%	16.00%	83,655,106.00	2,772
04/01/2024		108.00%	-12.32%	48.00%	15.50%	78,611,492.00	2,717
04/01/2024		106.00%	-10.24%	41.00%	20.00%	65,308,653.34	2,330
04/01/2024		79.20%	17.63%	10.00%	18.00%	26,545,565.18	898
04/24/2024		101.00%	-5.55%	39.00%	16.00%	26,200,160.52	700
04/01/2024		82.00%	14.72%	31.00%	25.00%	20,566,755.83	544
04/01/2024		86.07%	10.49%	15.00%	15.38%	17,793,600.00	705
04/30/2024		100.93%	-5.47%	45.00%	20.00%	15,645,387.00	623
04/01/2024		98.10%	-2.02%	15.00%	15.00%	13,415,528.00	368
04/19/2024		71.57%	25.21%	4.00%	18.00%	12,839,378.57	627
04/01/2024		82.00%	14.72%	20.00%	18.00%	12,094,427.00	486
04/01/2024		93.60%	2.66%	34.00%	20.00%	11,704,789.29	512
04/01/2024		97.01%	-0.89%	30.00%	17.00%	10,108,378.07	286
TOTAL						PHP 1,170,593,018.03	43,604

All were priced within the pricing requirement of either 80 CM or 2000 CM. The ending LRs were also reported with the ending CM for coverage year 2023 to 2024 with the applicable increases.

The non-renewed accounts were reported as follows, with those highlighted in red as the major non-renewed accounts

Effective Date	COMPANY NAME	Reason for non-renewal	Chosen Provider	Years with maxicare	MLR	EXPIRED CM	NEW CM	INCREASE	2023 HEADCOUNT	2023 TCV WITHOUT VAT
1-Jan-23					89.00%	7.44%	15%	17%	11,532	PHP 191,550,570.01
1-Jan-23					98.00%	-1.92%	18%	43%	3,220	PHP 89,396,962.08
1-Jan-23					118.00%	-22.72%	9%	42%	7,899	PHP 88,410,879.00
1-Jan-23					102.00%	-6.08%	16%	38%	4,600	PHP 87,805,976.89
1-Jan-23					109.00%	-13.36%	18%	51%	7,200	PHP 77,736,254.00
1-Jan-23					ASO	3.80%	7%	ASO	1,618	PHP 41,105,435.44
1-Jan-23					ASO	11.30%	20%	ASO	2,848	PHP 39,481,486.52
1-Jan-23					95.00%	1.20%	15%	33%	1,613	PHP 35,054,187.35
1-Jan-23					92.00%	4.32%	28%	39%	1,667	PHP 31,998,524.20
1-Jan-23					92.00%	4.32%	17%	28%	1,494	PHP 26,534,041.73
18-Jan-23					94.00%	2.24%	15%	28%	741	PHP 19,560,726.78
1-Jan-23					79.00%	17.84%	19%	17%	484	PHP 15,621,086.24
1-Jan-23					110.00%	-14.40%	18%	55%	1,015	PHP 15,192,079.99
1-Jan-23					87.00%	9.52%	17%	28%	856	PHP 12,019,856.00
18-Jan-23					76.00%	20.96%	18%	3%	689	PHP 9,003,637.23
16-Feb-23					162.00%	-68.48%	15%	113%	978	PHP 20,034,000.12
24-Feb-23					81.00%	15.76%	18%	59%	1,786	PHP 13,251,119.82
1-Feb-23					ASO	8.50%	13%	ASO	464	PHP 9,502,288.74
1-Mar-23					98.13%	-2.06%	18%	41%	5,887	PHP 50,501,863.38
18-Mar-23					99.00%	-2.96%	18%	40%	1,376	PHP 15,480,288.42
15-Apr-23					110.00%	-14.40%	18%	41%	4,799	PHP 56,568,562.99
1-Apr-23					95.00%	1.20%	16%	29%	23,529	PHP 300,010,883.76
		TOTAL							86,295	PHP 1,245,820,710.69

were not profitable with an ending CM of negative 14% for . and 1% for . Total TCV without VAT for both of these accounts which were at Php 356 Million.

The highest gain came from Etiqa because of the shift of to Maxicare at Php 380 Million:

Competitor	Competitive Gain # Headcount	Competitive Gain # of Account	Competitive Gain Total Contract Value	Competitive Loss # Headcount	Competitive Loss # of Account	Competitive Loss Total Contract Value	Net # of Headcount	Net # of Account	Net TCV	%
ETIQA	15,459	4	404 M	1,460	4	22 M	13,999	0	382 M	40.25%
FRESH ACCOUNTS	4,261	23	53 M	0	0	0 M	4,261	23	53 M	5.59%
GREPALIFE	2,427	1	39 M	0	0	0 M	2,427	1	39 M	4.11%
MAXICARE	392	7	10 M	75	2	3 M	1,598	5	7 M	0.69%
PACIFIC CROSS	279	3	5 M	0	0	0 M	279	3	5 M	0.50%
CAREHEALTH PLUS	100	1	1 M	0	0	0 M	100	1	1 M	0.10%
SELF-ADMINISTERED	0	0	0 M	220	2	2 M	-220	-2	-2 M	-0.21%
EASTWEST	148	1	2 M	396	1	4 M	-248	0	-2 M	-0.24%
FORTICARE	0	0	0 M	367	1	4 M	-367	-1	-4 M	-0.40%
HIVE HEALTH	0	0	0 M	341	1	5 M	-341	-1	-5 M	-0.54%
LIFE AND HEALTH	0	0	0 M	1,612	1	7 M	-1,612	-1	-7 M	-0.78%
HC&D	0	0	0 M	978	1	20 M	-978	-1	-20 M	-2.11%
NONE	161	2	4 M	2,452	15	32 M	-2,291	-13	-28 M	-2.94%
PHILCARE	1,585	4	29 M	5,126	3	61 M	-3,541	1	-32 M	-3.34%
VALUCARE	1,120	1	14 M	5,887	1	51 M	-4,767	0	-36 M	-3.82%
OTHERS/DID NOT DISCLOSE	249	3	5 M	7,303	33	93 M	-7,054	-30	-87 M	-9.22%
GENERALI	0	0	0 M	8,031	3	90 M	-8,031	-3	-90 M	-9.49%
INSULAR LIFE	117	1	2 M	5,931	7	115 M	-5,814	-6	-113 M	-11.96%
INTELLICARE	8,742	17	246 M	30,576	9	408 M	-21,834	8	-162 M	-17.10%
MEDICARD	2,789	13	51 M	12,755	10	257 M	-9,966	3	-205 M	-21.66%
COCOLIFE	58	1	2 M	15,420	10	252 M	-15,362	-9	-251 M	-26.44%
ICARE	0	0	0 M	39,327	3	388 M	-39,327	-3	-388 M	-40.97%
TOTAL	37,887	82	866 M	138,257	107	1814 M	-99,089	-25	-948 M	100.00%

The highest net loss by number of accounts were from Cocolife. The biggest loss based on TCV was

- Corporate Gain & Loss JAN - APR 2024

Highest Gain					
EFFECTIVE DATE	ACCOUNT NAME	TCV (M)	Headcount	Previous Provider	CM
1-Jan-24		380	13,909		3%
25-Jan-24		11	1,010		25%
1-Feb-24		7	296		25%
15-Feb-24		3	244		25%

Highest Net/Loss					
EFFECTIVE DATE	ACCOUNT NAME	TCV (M)	Headcount	Chosen Provider	LR
1-Jan-23		191	11,532		89%
18-Jan-23		19	741		94%
24-Feb-23		13	1,786		81%
1-Feb-23		9	464		ASO
27-Jan-23		5	250		100%
17-Feb-23		4	100		15%
1-Feb-23		3	136		79%
4-Feb-23		2	142		66%
14-Jan-23		1	63		57%%
16-Apr-23		1	206		70%

Highest Loss					
EFFECTIVE DATE	ACCOUNT NAME	TCV (M)	Headcount	Chosen Provider	LR
1-Jan-23		300	24,485		N/A
1-Jan-23		35	484		95%
1-Jan-23		15	1,613		79%
20-Jan-23		2	94		101%
1-Feb-23		27	1,663		104%
18-Mar-23		15	1,376		99%
16-Mar-23		4	557		77%
1-Feb-23		5	216		146%

The below were the accounts that shifted to which were currently being monitored:

Highest Net/Loss					
EFFECTIVE DATE	ACCOUNT NAME	TCV (M)	Headcount	Chosen Provider	LR
1-Jan-23		88	7,899		118%
1-Jan-23		72			
1-Apr-23		300	23,529		95%

v. Consumer Sales Report

On the consumer sales report, Ms. Rodelee Uy ("Ms. Uy") discussed that the sales performance for April 2024 was at 89.03% with 13.83% growth from 2023.

For SME Gain & Loss, the highest gain was from fresh accounts at Php 147 Million and the highest loss came from the accounts who opted not to get any more coverage:

On both businesses, new business renewal had growth, so there was an achievement of Php 530 Million vis-à-vis the target with 19.23% growth. In terms of performance vis-à-vis the target, it was just a 78.35% achievement.

The renewal business was at Php 970 Million vis-à-vis the target, which was a 96.19% growth.

The table below shows the month-on-month performance for the month of April 2024, which would end at 92%:

- Sales Performance for APR 2024
  - 89.03% achievement
  - 13.83% growth from 2023
- SME Gain & Loss
  - Highest Gain *Fresh Accounts at 147M*
  - Highest Loss *None at 73M*
  - Highest Net Gain *Fresh Accounts at 147M*
  - Highest Net Loss *None at 73M*

Jan-Apr 2024

	2024 Actual Performance (M)	2023 Actual Performance (M)	% Growth	Php Growth (M)	2024 Actual Target	% Performance
New Business	530	445	19.23%	85	676	78.35%
Renewal Business	970	873	11.08%	97	1008	96.19%
Consumer Total	**1,500**	**1,318**	**13.83%**	**182**	**1,685**	**89.03%**

All of the products for B2C were able to grow. The sales for MyMaxicare went down as there was a big variance specifically for new business.

The MyMaxicare growth was only at 10% which can be attributed to the increase in premium. Conversations with the product and development team was to develop an affordable individual and family product.

Mr. B. Go inquired whether MyMaxicare was charged on a one-time basis or monthly. The reply was that it would depend on the modal factor which was per quarter, semi-annual, and annual.

MyMaxicare was a full-service in-patient and out-patient annual checkup emergency, except that it was purchased by either an individual or family, which was different from an SME.

It was discussed that MyMaxicare was the most profitable product and this would be maintained. The plan was develop a more affordable product, which was the base product based on the OGSM discussion.

The major factors affecting the sales performance were the low performance of the agents and brokers:

Consumer Sales Report : Jan-Apr Sales Performance per Product Type
B2B - SME

PRODUCT	2024 YTD SALES PERFORMANCE				2024 VS 2023			
	TARGET	ACTUAL	VARIANCE	%	2024	2023	VARIANCE	GROWTH
MAXICARE PLUS - NB	254.5M	194.8M	-59.7M	77%	194.8M	158M	36.6M	23%
MAXICARE PLUS - RB	729.0M	732.7M	3.7M	101%	732.7M	687M	45.6M	7%
STARTER - NB	27.5M	18.9M	-8.6M	69%	18.9M	16M	3.1M	20%
STARTER - RB	44.5M	46.2M	1.7M	104%	46.2M	32M	13.8M	42%
MBE - NB	15.3M	3.0M	-12.4M	19%	3.0M	2M	1.4M	86%
MBE - RB	1.1M	1.0M	-.1M	92%	1.0M	M	1.0M	#DIV/0!

SME BOXED TYPE	2024 vs 2023		
SALES CHANNELS	YTD Apr 2024	LY Apr 2023	GROWTH
AGENTS	472,887,597	446,105,800	6.00%
BROKERS	64,471,213	60,563,910	6.45%
DIRECT	155,632,004	139,282,555	11.74%

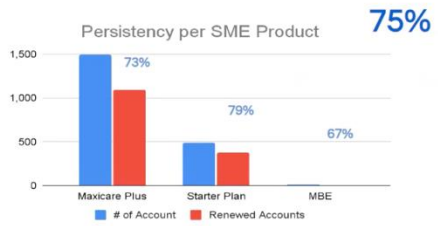
Since the drivers for Maxicare Plus were the agents, there must be an incentive program for such agents.

The products whose number of enrollees went down were , and

PRODUCT TYPE	CURRENT MONTH				PREVIOUS MONTH				INCREASE/DECREASE		VAR %	
	# OF ACCOUNTS	PERCENT SHARE	HEADCOUNT	PERCENT SHARE	# OF ACCOUNTS	PERCENT SHARE	HEADCOUNT	PERCENT SHARE	# OF ACCOUNTS	HEADCOUNT	# OF ACCOUNTS	HEADCOUNT
	29,770	23.65%	29,770	1.70%	27,023	21.55%	27,023	1.53%	2,747	2,747	10.17%	10.17%
	4,273	3.40%	11,426	0.65%	4,266	3.40%	11,406	0.65%	7	20	0.16%	0.18%
	12	0.01%	95	0.01%	13	0.01%	101	0.01%	-1	-6	-7.69%	-5.94%
	12,865	10.22%	12,865	0.73%	12,262	9.78%	12,262	0.70%	603	603	4.92%	4.92%
	22,347	17.76%	22,347	1.27%	22,225	17.72%	22,225	1.26%	122	122	0.55%	0.55%
	4,830	3.84%	4,830	0.28%	5,943	4.74%	5,943	0.34%	-1,113	-1,113	-18.73%	-18.73%
	9,018	7.17%	9,018	0.51%	11,456	9.13%	11,456	0.65%	-2,438	-2,438	-21.28%	-21.28%
	8,716	6.93%	8,716	0.50%	8,465	6.75%	8,465	0.48%	251	251	2.97%	2.97%
	25,404	20.18%	25,404	1.45%	25,012	19.94%	25,012	1.42%	392	392	1.57%	1.57%
SUBTOTAL	**117,235**	**93.15%**	**124,471**	**7.10%**	**116,665**	**93.03%**	**123,893**	**7.03%**	**570**	**578**	**0.46%**	**0.00%**
	5,351	4.25%	166,941	9.52%	5,464	4.36%	168,839	9.58%	-113	-1,898	-2.07%	-1.12%
	1,686	1.34%	11,724	0.67%	1,682	1.34%	11,601	0.66%	4	123	0.24%	1.06%
	98	0.08%	2,648	0.15%	98	0.08%	2,447	0.14%	0	201	0.00%	8.21%
SUBTOTAL	**7,135**	**5.67%**	**181,313**	**10.34%**	**7,244**	**5.78%**	**182,887**	**10.38%**	**(109)**	**(1,574)**	**(0.00)**	**(0.01)**
TOTAL :	**125,857**	**100 %**	**1,754,031**	**100 %**	**125,412**	**100 %**	**1,761,805**	**100 %**	**461**	**-996**	**0.35%**	**-0.44%**

**data as of May 1, 2024*

The highest gain was recorded to have come from the fresh accounts and the lowest net loss from accounts that opted to get another HMO:

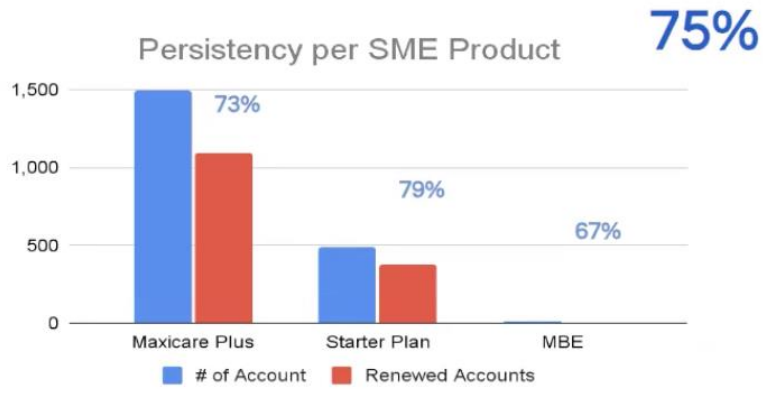


	Reason for Non Renewal	# of DNR	TCV (Net)
1	INCREASED RATES HIGH LOSS RATIO 2 YRS	130	48M
2	BUDGET CONSTRAINTS	100	45M
3	DISAFFILIATION OF HOSPITALS	15	20M
4	INCREASED RATES HIGH LOSS RATIO 1 YR	47	13M
5	UNDECIDED	37	9M
6	CHANGE IN MANAGEMENT WITH PREFERRED HMO	14	9M
7	ACCOUNT CLOSED SHOP/ CEASED OPERATION	24	7M
8	SERVICE ISSUE DUE TO MAXICARE	12	7M
9	CANNOT MEET MINIMUM HEADCOUNT OF THE PROGRAM	7	1M
10	NO/ LIMITED ACCREDITED PROVIDERS IN THE AREA	6	1M

Jan- Apr Maxicare Plus Accounts Persistency

MONTH	NO. OF MPLUS ACCOUNTS PER MONTH	NO. OF ACCOUNTS FOR TRANSFER TO CORP (2 YRS HIGH LR)	%TRANSFER TO CORP ACCOUNTS %	NO. OF RENEWED ACCOUNTS	RENEWAL PERSISTENCY %	NO. OF DNR	DNR %	UNDER NEGO	AWAITING QUOTATION / REVISED QUOTATION
JANUARY	212	39	18%	8	21%	31	79%	0	0
FEBRUARY	357	58	16%	11	19%	47	81%	0	0
MARCH	541	77	14%	14	18%	60	78%	3	0
APRIL	385	67	17%	11	16%	39	58%	9	3
TOTAL	1495	241	16%	44	18%	177	73%	12	3

The persistency rate with SME was at 75%: 73% for Maxicare Plus; 79% for Starter Plan; and 67% for MBE:



The major reasons for non-renewal were reported as follows:

	Reason for Non Renewal	# of DNR	TCV (Net)
1	INCREASED RATES HIGH LOSS RATIO 2 YRS	130	48M
2	BUDGET CONSTRAINTS	100	45M
3	DISAFFILIATION OF HOSPITALS	15	20M
4	INCREASED RATES HIGH LOSS RATIO 1 YR	47	13M
5	UNDECIDED	37	9M
6	CHANGE IN MANAGEMENT WITH PREFERRED HMO	14	9M
7	ACCOUNT CLOSED SHOP/ CEASED OPERATION	24	7M
8	SERVICE ISSUE DUE TO MAXICARE	12	7M
9	CANNOT MEET MINIMUM HEADCOUNT OF THE PROGRAM	7	1M
10	NO/ LIMITED ACCREDITED PROVIDERS IN THE AREA	6	1M

Mr. Macapagat reported on the 2024 profitability of all boxed type products, the same methodology reports would be maintained and applied for the next three (3) months:

Summary of results from January'24 to April'24									
		Apr-24		Mar-24		Feb-24		Jan-24	
Products		Contribution Margin	Net Income	Contribution Margin	Net Income	Contribution Margin	Net Income	Contribution Margin	Net Income
B2B Products									
		16,912,467	(7,190,615)	23,107,609	(11,127,579)	6,105,773	(13,752,609)	28,115,161	5,419,336
		2,019,822	157,335	3,012,376	326,425	2,431,529	690,121	1,250,215	(115,208)
		43,873	(164,677)	(15,595)	(291,071)	(418,422)	(459,438)	31,585	(72,724)
Total B2B		18,976,162	(7,197,957)	26,104,389	(11,092,226)	8,118,880	(13,521,926)	29,396,961	5,231,404
B2C Products									
		19,840,058	9,923,314	23,894,818	10,209,228	24,290,614	13,146,213	25,257,099	16,170,917
		(3,203,898)	(4,017,654)	(2,947,136)	(4,460,900)	(2,515,822)	(3,185,944)	(2,743,691)	(3,220,104)
	New Rate	(2,586,032)	(2,939,524)	(1,860,292)	(3,160,973)	(1,566,668)	(1,826,316)	(1,830,292)	(1,885,978)
	Old Rate	(617,866)	(1,078,129)	(1,086,845)	(1,299,929)	(949,154)	(1,359,628)	(913,399)	(1,334,126)
		(2,361,266)	(3,649,957)	(2,236,384)	(4,415,489)	(3,871,340)	(4,837,077)	(3,891,840)	(4,771,709)
	New Rate	(383,454)	(1,850,228)	981,272	(946,647)	(92,964)	(1,605,032)	180,369	(1,000,916)
	Old Rate	(1,977,812)	(1,799,730)	(3,217,656)	(3,468,844)	(3,778,376)	(3,232,046)	(4,072,208)	(3,770,792)
		(23,953,662)	(20,324,383)	(25,123,196)	(21,269,475)	(22,751,272)	(18,508,721)	(19,123,081)	(17,524,105)
	New Rate	(14,402,987)	(12,355,248)	(15,031,048)	(12,595,543)	(10,197,928)	(8,399,026)	(7,454,139)	(6,762,740)
	Old Rate	(9,550,675)	(7,969,135)	(10,092,148)	(8,673,931)	(12,553,344)	(10,109,696)	(11,668,942)	(10,761,365)
Total B2C		(9,678,768)	(18,068,680)	(6,411,898)	(19,936,636)	(4,847,821)	(13,385,529)	(501,513)	(9,345,001)
Grand Total		9,297,394	(25,266,637)	19,692,491	(31,028,861)	3,271,060	(26,907,455)	28,895,448	(4,113,596)

A positive CM was consistently being generated for

However, in terms of net income, not all of these products showed a positive figure given the allocation of OPEX and other items.

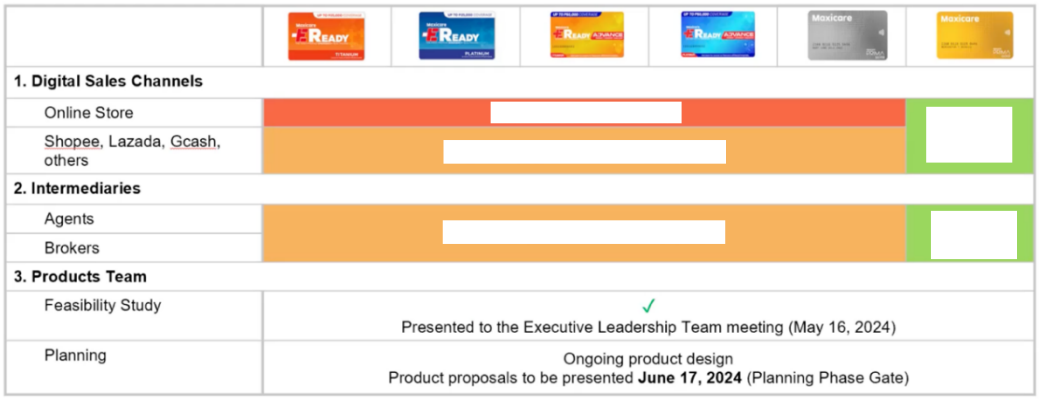
	Apr 2024	Mar 2024	Feb 2024	Jan 2024
	7%	10%	3%	12%
	14%	20%	18%	9%
	3%	-1%	-35%	3%
Total B2B	**8%**	**10%**	**3%**	**12%**
	32%	37%	39%	40%
	-110%	-98%	-98%	-131%
	-18%	-16%	-32%	-34%
	-90%	-85%	-93%	-76%
	-186%	-209%	-203%	-165%
Total B2C	**-10%**	**-6%**	**-5%**	**-1%**

Approval from the Executive Committee was sought to reprice from 10% increase to increase, and this would be at :

The accounts with loss ratio of 200% and above on the first year was requested to be maintained on the main pool – Maxicare Plus pool.

Approval from the Executive Committee was likewise sought to discontinue selling the

Next Steps: EREADY, EREADY ADVANCE and PRIMA



1. Digital Sales Channels	
Online Store	
Shopee, Lazada, Gcash, others	
2. Intermediaries	
Agents	
Brokers	
3. Products Team	
Feasibility Study	✓ Presented to the Executive Leadership Team meeting (May 16, 2024)
Planning	Ongoing product design Product proposals to be presented **June 17, 2024** (Planning Phase Gate)

The feasibility study was already presented to the Executive Leadership Team last 16 May 2024, and the product would have to be finalized for presentation on 17 June 2024. This would be relaunched by 01 September 2024.

The eReady products on emergency care were being transitioned into an insurance type emergency product. Selling of the same would be stopped already, with a relaunch at a later date, focusing on emergency and accident only.

For Prima Silver, the product would be tweaked in such a manner that IC Approval must be procured to contain the benefits further. Prima Gold was reported to be profitable.

	Prima Gold					Prima Silver				
April YTD 2024	***New Rate***	***Old Rate***	**Total**	**%**	vs Original	***New Rate***	***Old Rate***	**Total**	**%**	vs Original
Earned Membership Fees										
Commission Expense										
Total Revenue Net of Comm Exp										
MEDICAL UTILIZATION COST										
EICA										
Rider costs										
PCC Variable Costs										
Enrollment and Processing Charges										
Inefficiencies/Margins										
Not Covered										
Expired Cards										
TOTAL DIRECT COST										
CONTRIBUTION MARGIN										
Advertising cost										
Sales Incentive Program										
PCC Fixed Costs										
MHSI Margin										
Other Operating Expenses										
Indirect Member and LOA-related										
Total Indirect Cost										
INCOME (LOSS) FROM OPERATIONS										
Other Income, net										
INCOME (LOSS) BEFORE TAX										
PROVISION FOR INCOME TAX										
NET INCOME (LOSS)										

Request for Approval Incentive Program (Maxicare)

Jun

To drive and achieve additional upsell / cross-sell sales among Maxicare members, a request for the approval of an incentive program which would cost around [redacted] was sought. This would be based on performance.

Reporting on the last items for approval, Mr. Cayetano cascaded the following items which were also presented to the TTC[18] last 20 May 2024, *to wit*:

	Item	Budget Request for Approval
1	Additional Manpower Resource for Transformation	[redacted]
2	Implementation of Checkpoint Harmony Email Security	Additional budget of [redacted] from the original budget
3	eKYC Budget (Adera License and ECS Services)	

The total amount of items for approval was [redacted] Mr. Cayetano requested to reallocate the remaining surplus of the Automation Hero budget, amounting to [redacted] and an additional budget of [redacted] in order to satisfy the items listed above.

It was likewise explained that the amount indicated for #2 had been aligned with the JG Group but was described as a "conservative" amount because this price was based on the JG Email Security for Checkpoint Harmony. However, the quote for Maxicare yielded higher costs. As such, Mr. Cayetano reported that this cost could

[18] TTC: Transformation & Technology Committee

be eliminated altogether if Maxicare can secure a rate which was the same as that of the JG Group for Checkpoint Harmony.

Mr. B. Go sought clarification on the [redacted] cost for Item #1. He inquired whether such amount was considered as a recurring cost. Mr. Cayetano confirmed that it was, and that it would be such until December 2024 – for one (1) year.

Mr. Argos also clarified whether Item #1 was a reallocation of resources (i.e., hired personnel). Mr. Cayetano confirmed that the reallocation pertained to a reallocation of the remaining surplus of the Automation Hero budget worth [redacted].

Mr. Argos inquired as to the specific deliverables of the additional personnel. Mr. Cayetano explained that they were meant to provide support to the entire MIS[19] initiative.

As an action item, Mr. Argos noted that the milestones of all MIS capabilities must be presented: (1) When it would go online, and (2) What products would it support, etc.

As to the budget for **eKYC**, Mr. A. Go pointed out that the same had been approved already.

In sum, the Committee noted that the proposed budgets were mere reallocations of an existing budget. The reporters are not asking for additional budget, rather, they were merely requesting for a reallocation of the remaining surplus of the Automation Hero budget, *viz*:

Direct Cost/Opex	Expenses Classification	Expense	Amount	Vendor	Department	Remarks
Opex	Personnel	Additional Manpower Resource for Transformation Division	[redacted]	N/A	ICT / ES	Additional manpower resource for the Transformation Division that would handle the technology roadmap and projects: • Enterprise Services: 5 Assistant Managers • Enterprise Services: 6 Supervisors • Information & Communication Technology IT Operations: 2 Assistant Managers • Information & Communication Technology IT Operations: 4 Supervisors Details: Transformation Division Needed vs Present
Opex	System Repairs & Maintenance	Email Security	[redacted]	Will ride on JG Group. Their vendor is UAS	ICT	This cost can be eliminated altogether if we can secure a rate the same as JG for Checkpoint Harmony
Opex	System Repairs & Maintenance	eKYC	[redacted]	ECS / Adera	ICT	eKYC cost, 3 year TCO, combination of Adera licenses and ECS implementation services
Total			[redacted]			

V. OTHER MATTERS

There were no other matters discussed.

[19] MIS: Maxicare Insurance System

VI. ADJOURNMENT

There being no other matters discussed and upon motion duly seconded, the meeting was adjourned.

Prepared by:

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ATTY. DANNY E. BUNYI
Corporate Secretary

Attested by:

DocuSigned by:
...E0AEBD2CE0F4EB...

ANTONIO L. GO

DocuSigned by:
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LANCE Y. GOKONGWEI

Signed by:
...0CAD12FE4FC...

ESTHER WILEEN S. GO

DocuSigned by:
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BRIAN M. GO

Signed by:
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RENE J. BUENAVENTURA

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MICHAEL P. LIWANAG

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ROBERTO M. MACASAET, JR.