MAXICARE HEALTHCARE CORPORATION

MINUTES OF THE EXECUTIVE COMMITTEE MEETING

Boardroom, Maxicare Tower
203 Salcedo Street, Legaspi Village, Makati City[1]
24 March 2025, 8:00 AM

PRESENT:

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

ALSO PRESENT:

CHRISTIAN S. ARGOS
BACH JOHANN SEBASTIAN
GRACE AGLUBAT
JASPER HENDRIK CHENG
FIONA MARIE L. VICTORIA
RODELEE UY
JOSEPHINE LOPEZ
JOSE PASTOR Z. PUNO
JOE MERITTO P. BUOT
ELIZABETH GREGORIO
RAYMOND HERNANDEZ
JAY MAURICIO
JERRY PEREZ
KURLEIGH GACUTAN
PATRICIA LOPEZ
ANTHONY PEREZ
KAREN NINA ALMONTE
MIKE MANRIQUE
RACQUEL ADORABLE
LAURENZ DALANGIN
JENINA JOY MALAPITAN
LOREN DEQUINA
ATTY ANDREW FORNIER
ATTY. DANNY E. BUNYI[2]
ATTY. MARY ZOELLI R. VELASCO
MARIA ESTRELLA GARCIA
RIZ GAURAN

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

[2] Atty. Bunyi was present in this meeting until the first report.

I. Call to Order

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

II. Certification of Quorum

The Corporate 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.

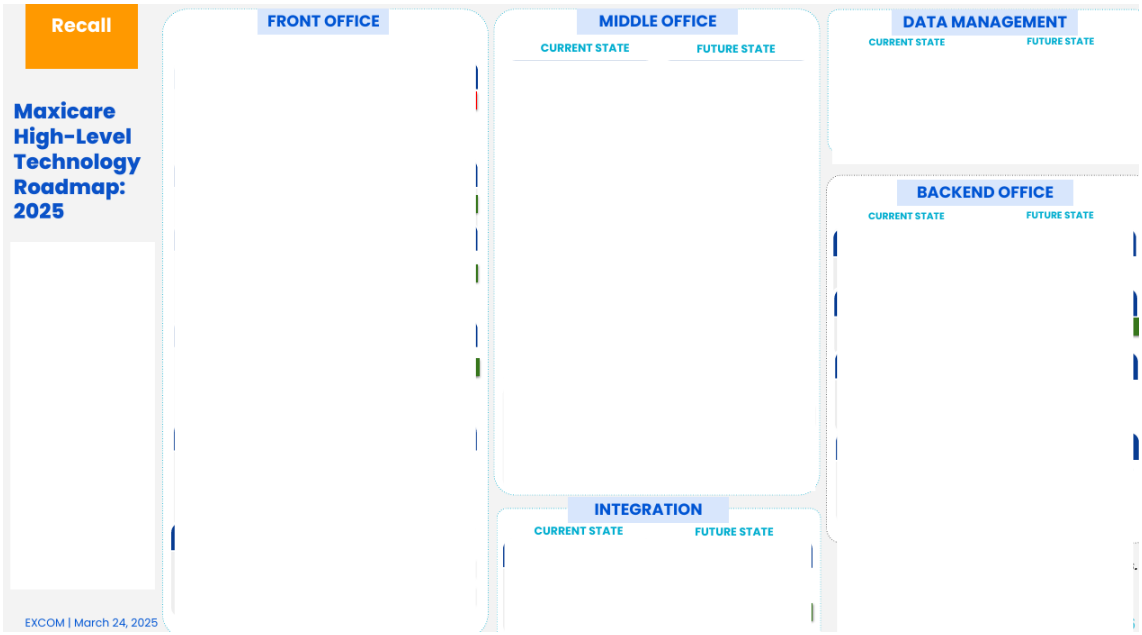
III. Approval of the Minutes of the Previous Meeting

Upon motion duly made and seconded, and there being no objection, the Committee approved the previous Minutes of the Executive Committee Meeting dated 26 February 2025.

IV. Unified Systems Process

A. Process & Systems

Ms. Grace Aglubat ("Ms. Aglubat") opened the discussion on Process & Systems with a recap of the Maxicare High-Level Technology Roadmap, as presented below:



She explained that the roadmap primarily focused on the implementation, which would replace Maxicare's several legacy systems including SAP, C4C, Payorlink 1 and 2 as well as the Corporation's other systems. The transition was designed to unify and simplify the core systems. It would also enhance migration across business functions and improve efficiency and scalability. She noted that the platform was expected to integrate seamlessly with Maxicare's existing systems.

Mr. A. Go remarked that this was good. However, motherhood statements are difficult to understand. He instructed what was being done with SAP must be detailed and the improvements expected with moving t must be specified (i.e. in terms of efficiency, income, headcount reduction).

Ms. Aglubat mentioned that the operational metrics as well as cost savings would be presented in the next Committee meeting. Mr. A. Go instructed that the entire process must be automated. He likewise inquired on how this would affect Genesys. Ms. Aglubat responded that there would be member integration.

Mr. A. Go noted that with respect to the call centers, they can look into artificial intelligence ("AI") to answer the queries. Mr. Argos explained that Genesys is on the telephony side. He explained that Maxicare can ride on top of the AI and mentioned that there would be an AI trial for dental services and steerage to PCCs. He inquired with Ms. Fiona Victoria ("Ms. Victoria") whether this would be in April 2025, which she subsequently confirmed.

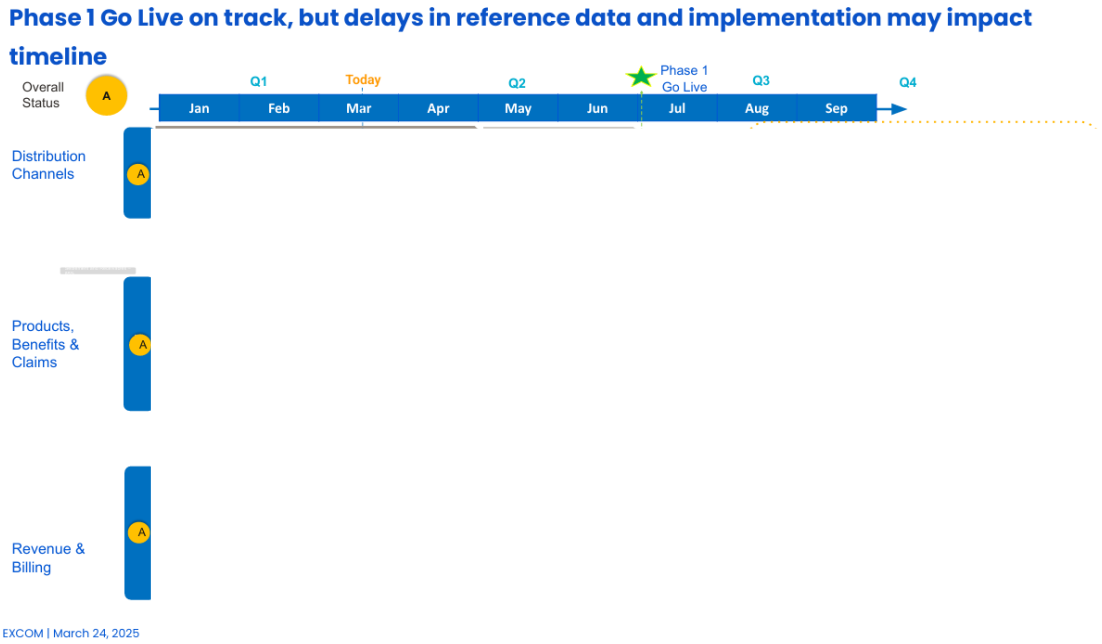
Mr. A. Go inquired whether this may be done without Genesys, as telephones may soon be obsolete. Mr. Argos explained that Genesys supports WhatsApp, Viber, and emails and that the routing behind this is Maxicare's unified communications system.

Seeing the matter from another perspective, Mr. A. Go asked how many minutes it takes to answer a call. He mentioned that the time this takes should be halved. He mentioned that AI can help in this aspect especially with regard to the agents. He further noted that self-service mechanism would not even require agents. Ms. Victoria explained that Maxicare had modelled different touch points that would be modelled automatically or via AI. She shared that one would be up for review in the coming week.

Mr. A. Go then asked if he would be able to see a net income with these initiatives. Mr. Argos answered that this remains to be the target. Mr. A. Go said that he was illustrating how to set the cost so that the Corporation can realize income.

B. Project

Ms. Aglubat proceeded with the discussion on the updates of the Project implementation.



Mr. A. Go reiterated that he would like to see the impact of this project. Ms. Aglubat responded that the above slide was just a status update and that the team was still consolidating the metrics that would be used to gauge the impact of the project.

As to operational efficiency, Mr. A. Go inquired if this was not already assessed. He emphasized that the reduction in costs must be seen with this initiative. Ms. Victoria responded that they were already reviewing operational efficiency in terms of the completed milestones in relation to the several modules of She mentioned that the study of the operational efficiency and the reduction in costs was still currently ongoing and that the F1 forecast was aimed to be released in the next Committee meeting.

Mr. Gokongwei clarified whether there was a business case when was approved. This was confirmed by Ms. Victoria. Mr. Argos and Ms. Victoria explained that this was to be updated based on the current schedule, such as in consideration of the updated headcount. Mr. Argos noted that the team's commitment was to report on the savings to be realized in using

Mr. A. Go then instructed that Maxicare should be more careful in disaffiliating the providers as some complaints have been noted with regard to disaffiliation. He stated that the Corporation should understand where the providers were coming from. He noted that everyone has significance in the organization.

In relation to this, Mr. Gokonwei opined that the Corporation should be selective on who is removed, such as in the case of Ms. Victoria clarified that , is back on board as an agreement was reached especially in terms of cost. Mr. A. Go noted that the criteria for disaffiliation must be revisited.

In addition, Mr. A. Go pointed out the importance of seamless billing and in determining the proper algorithm such that difficulties with the RTP[3] would be eliminated. He reiterated that proper payments to the providers is essential for them to likewise properly serve the Maxicare members. He emphasized that every time a member cannot avail the benefits of the Maxicare membership card then there would be a consequent brand damage to the Corporation.

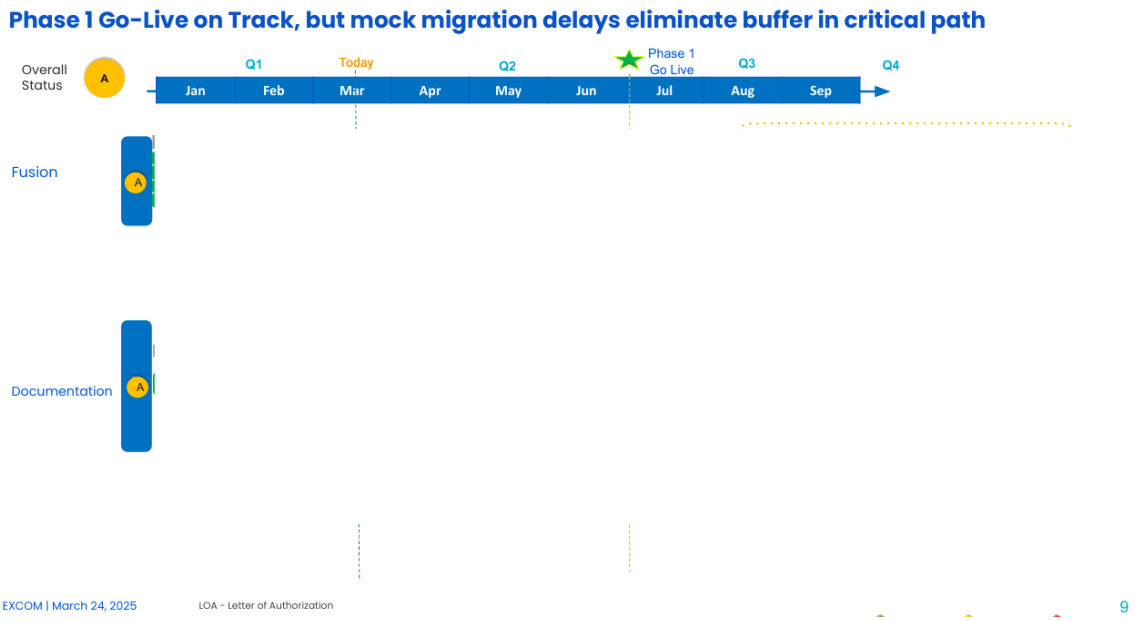
Mr. Argos agreed with Mr. A. Go and responded that the team had taken note of the lessons on the initial version of the "seamless billing" and that controls have been considered. Mr. A. Go remarked that there is no perfect system and once a system is thoroughly mastered, it soon becomes obsolete. Hence, there must be continuing improvements and updates of systems such as AI.

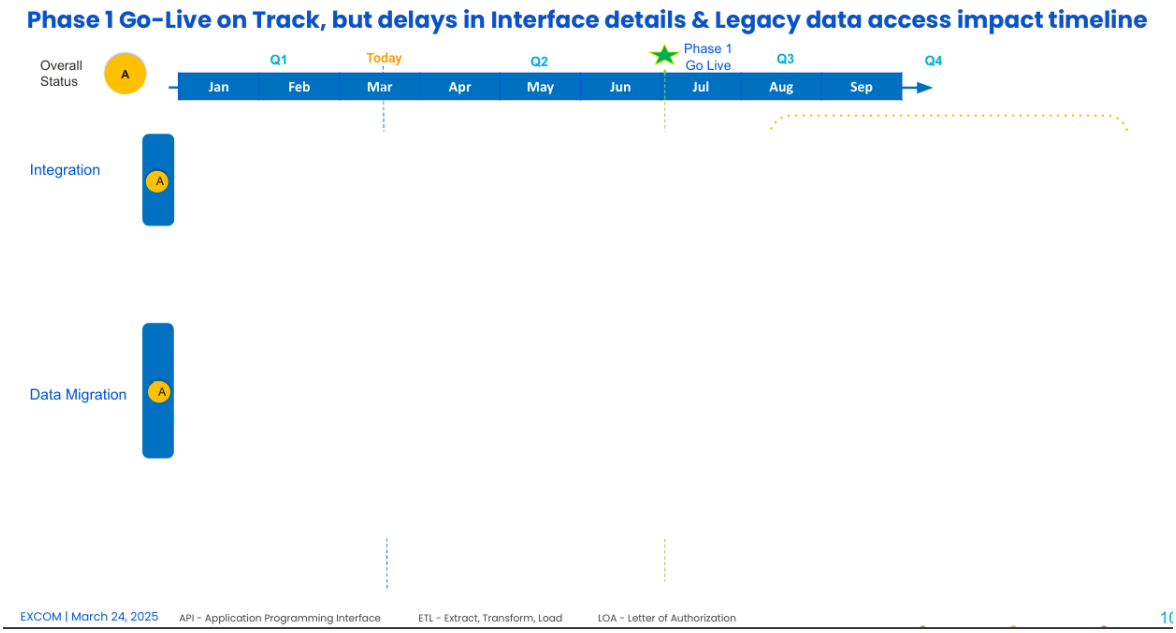
Ms. Aglubat continued with her report and mentioned that as of 20 March, Phase 1 Go Live was on track. She highlighted the timeline with respect to the application, integration, and data migration. As seen on the table above, for all of the work streams and modules, there was already a 40-55% completion. To this, Mr. A. Go reiterated that the report must be more specific as the percentage completion could not be validated.

[3] RTP: Return to Provider.

Mr. Renato Puno ("Mr. Puno") proposed that a certain process be elaborated to exhibit the effect of the project. Mr. A. Go emphasized that the data should show how the targets would be met.

Ms. Aglubat directed the Committee to the slide below as this shows the areas where there had been some issues. Mr. A. Go remarked that this was what he wanted to know as well especially with respect to the proposed mitigation strategies.





She explained that to fast track the implementation process, access was sought with the Payorlink 1 and 2 databases. Mr. A. Go noted that these contain sensitive data and if another data was created for the team to use for assessment purposes (so as not to touch this sensitive data), then this should not be a showstopper.

Ms. Esther Go ("Ms. Go") added that "deal tables" have been available since last week and access to these had been verified. She explained that the difference between deal tables and "source tables" is that the latter is messy and complicated while the former is simplified by entity.

Ms. Aglubat mentioned that they have checked the tables, however ,the credentials have yet to be provided. A follow-up email was sent to a certain Michael and Israel for access credentials. Mr. A. Go asked for a copy to ensure proper handling. Ms. Go explained that Michael sent the credentials individually due to data privacy purposes. She requested that access be verified by Ms. Aglubat's team within the day.

Mr. Argos added that the team likewise needs "read only access" to the data so that the source information may be studied. The team still has to extract and load the information into Oracle. He noted that this is a learning from Emedcore and Emedcore+. He emphasized that the team sought to understand where the data was coming from so that the team can determine which field the data may be mapped.

With respect to the view tables, Mr. Argos explained that the tables for utilization, billing, etc. reports had duplicate entries so the team wanted to take a step back and work together with Medilink to make informed choices.

Ms. Go suggested to start working with Michael and noted that the presence of both Michael and Israel was not necessary since the latter works with applications, which was not needed in this matter.

Mr. A. Go posited that with respect to existing challenges, what is important is to determine how to move faster. He asked how far the delay was and if the team can catch up. Ms. Aglubat responded that with respect to data migration, the delay was about three weeks and a projected combined five weeks delay with respect to the other items.

Mr. Argos emphasized the importance of mapping the data. Ms. Go mentioned that a working session should be conducted. Ms. Aglubat responded that they previously asked for this as well. Mr. Argos instructed that they shall make a fresh request and Ms. Go directed that she be copied in the email.

In response to Ms. Go's question about the insurance system, on whether the agreement was to move to from SAP first, Ms. Aglubat explained that the initial plan was to launch Maxihealth and Maxilife for . However, due to the complexity in the COA[4], which had a dependency on Maxicare, an alignment was needed across the group.

Mr. A. Go sought clarification on this matter to which Mr. Argos explained that the COA has to comply with IC[5] regulations as well as with respect to profitability and product reports. He explained that while the IC provides for broader standards, the Corporation has to go to a more granular level for the products. Mr. Argos and Ms. Aglubat clarified that the configuration for the COA had been completed as seen on the diagram above. Mr. Argos explained that what remained to done was to migrate the products in relation to the revenue. As to the expense side, information from Payorlink must be extracted with respect to the doctors and the hospitals. He explained that these were the items to be mapped.

As to Mr. A. Go's question on ACVP[6] and how data validation can be made, Mr. Argos explained that they have a report to be sent on 31 March. He discussed that ACVP was not a straight through process from end-to-end and the source of truth was the file sent by the client to Maxicare. Hence, the team made a temporary validation mechanism. Mr. A. Go mentioned that he preferred that profitability be measured every day or at the maximum, every week. Moving forward, Mr. Argos shared that the enrollment portion would move to myElth. As to profit and loss, this can be done monthly since revenue recognition is

[4] COA: Chart of Accounts.
[5] IC: Insurance Commission.
[6] ACVP: Account Viewpoint.

determined at that point. On the other hand, utilization can be tracked daily. EMF is now also tied directly with enrollment and processing.

As to Maxihealth and Maxilife, Ms. Go mentioned that considering that the latter has no integrations yet (Maxilife is still on MS Excel), their use of was unrelated to Payorlink. Ms. Aglubat agreed and mentioned that the team was doing mapping for data migration.

In response Ms. Go's query on when was the target date for these two companies to be on (accounting system), Ms. Aglubat said that the target date was the last week of May. She mentioned that there would be some testing so the completion date would be by June.

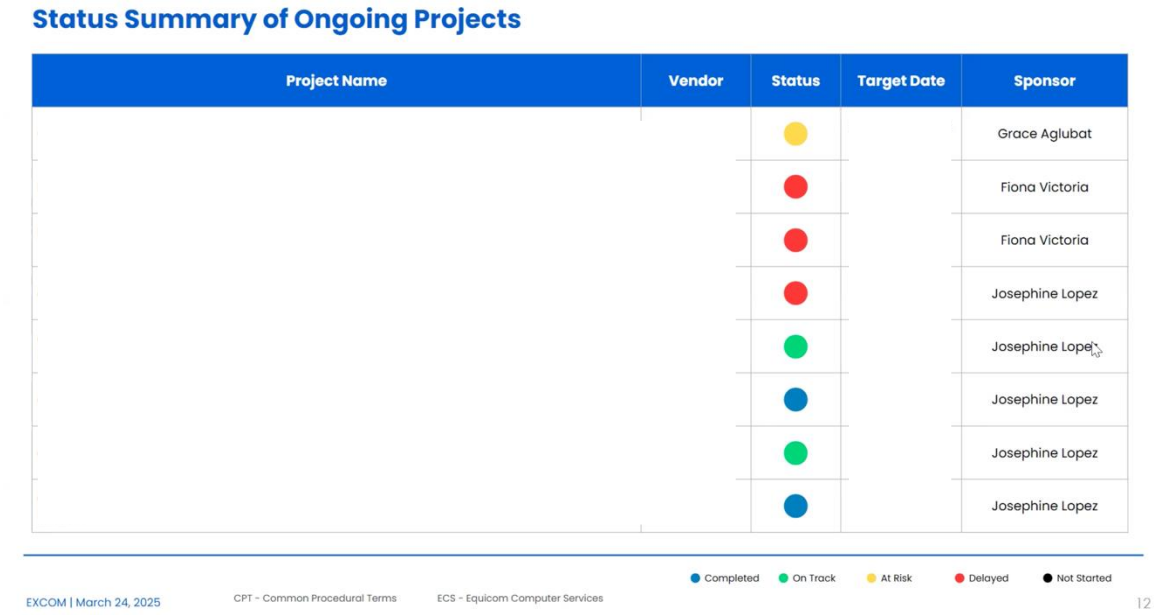
Mr. Argos added that not everything can be easily copied. For instance, as in the case of Maxilife, systems like still have to be considered. Moving forward, the intention is not to have any computations on MS Excel and that all these would be within or the actuarial software.

Ms. Go then clarified if the team meant to say that even if Maxilife does not have much in terms of data migration, the integrations with and the other systems add complexity therefore, the completion is targeted at the same time as Maxihealth. Mr. Argos noted that IFRS 17 compliance, which is , likewise has to be considered.

Ms. Go requested that the milestones for Maxihealth and Maxilife be marked. Mr. Argos responded that the milestones per entity would be made.

C. CIT Updates

Ms. Aglubat reported on the status summary of the ongoing projects as follows:



The would replace the existing customer portal for MaxiHealth Plus and member gateway. There were agreed functionalities to be delivered July last year, which were divided into three MVPs.

MVP 1 and MVP 2 were delayed for two weeks.

Mr. A. Go inquired as to the new timeline. Ms. Aglubat reported that the new timeline was set for . The final estimate has yet to be provided to the team for this one.

Mr. A. Go and Ms. Go asked what the issue was as to why the timeline was not met. Ms. Victoria discussed that there were some production issues attached to different entities. Mr. A. Go further suggested to focus on the member LOA request. Ms. Victoria responded that member LOA request was already live. She shared that there were some fixes to be made with regard to transaction history. While not completely done, she noted that there were still final reviews that needed to be completed. In response to Mr. A. Go's question, Ms. Victoria mentioned that another meeting was needed for SSO and eKYC to ensure that the requirements for these have been aligned. Mr. A. Go emphasized to give updates on such matters immediately.

Mr. Argos clarified that the project on KYC was not entirely dropped. KYC was originally scheduled for MVP 1.4, in line with reimbursement. However, it was decided that KYC will not be a roadblock nor a showstopper for the launch.

Mr. A. Go further discussed that eKYC for reimbursement was just one of the functions of eKYC. He stressed that in transactions with a provider, validation with KYC must be done immediately.

Mr. Argos discussed that based on the original timeline, if MVP 1.3.3 would have been completed by ,, then eKYC and all other access should have been updated to online. The reason why eKYC was delayed was because resources needed to be focused, which was mutually agreed upon to deliver all of the production fixes.

Mr. A. Go raised a query as to whether it would be possible and doable to use a
for LOA issues. Mr. Argos explained that under MVP 1.3.3, which was due to be delivered on 20 March 2025, the LOA issuance should have been delivered.

Mr. A. Go requested to be informed of details, such as defects that caused the delay on the target dates. Instructions were given to render a report on such reasons for the delay. On corporate clinics, Mr. A. Go further asked whether the same can be extended since the Teleconsults were already available. Ms. Victoria confirmed that they will explore the licensing report for the corporate clinics.

Mr. A. Go also stressed that the Teleconsult could not be installed without the connection of the line. Ms. Victoria explained that the Teleconsult was made first, and once the Videoconsult was out, the same was included in MVP 1.3.3 as an initial enhancement.

Mr. A. Go raised that several pieces of data were submitted to corporate clinics so that the data can be forwarded to other providers. He questioned whether the same was still an objective, and whether it remained doable.

Mr. Argos discussed that there were different scenarios for corporate clinics. There must first be an identification as to which of the corporate clinics will need the Teleconsult lines, and which of them will need the line first. Ms. Josephine Lopez ("Ms. Lopez") shared that they have about sites which have eMedcore, which means that they have the telephone lines.

Mr. A. Go raised that ECS has to be informed so that all the needed equipment can already be provided.

Ms. Go noted that in terms of work processes, there were refinements that needed to be done. On one hand, dates were struck out and delayed, while reports also indicated that there were requirements which were not signed off.

Mr. Argos explained that this was the reason why he suggested to Mr. A. Go to have joint weekly report sessions with ECS since what were referred to as requirements were actually part of fixes. Thus, they were not yet defined as they needed to be fixed.

Ms. Go and Mr. Argos discussed that the matter was really an alignment issue and to determine which items must be fixed. Mr. Argos committed to reconcile the issue by holding joint weekly meetings with ECS.

For the weekly meetings, Ms. Go volunteered to join the technical sessions, at least initially, just to push the discussions forward. Ms. Go emphasized that ground rules must be laid out regarding which must be fixed within the release as well as change requests. She further observed the same issue in other organizations, such that if business requirements were vaguely written and not drilled down to specific use cases, there arose different interpretations between the tester and end-user developers.

Mr. Argos agreed that the issue was really on alignment and work processes since the teams perform their work on a compartmentalized method.

For eMedcore+, Ms. Aglubat reported that there were inconsistencies on the data that were going to the This was one of the production issues identified during the last few months in resolving post-production issues. For instance, there were pieces of data as regards the date of birth and gender which were all incorrect in the eMedcore, and flowed into the These were also issues where additional corrections needed to be done in coding.

Mr. A. Go inquired whether the data can be validated via eKYC. Mr. Argos reported that there were instances when a certain address has been validated as correct but showed up as wrong in eMedcore.

Mr. Argos discussed that eMedcore plus has a separate database. As such, he noted that there should be a consolidated database that pulled all the data at the same time.

Mr. Brian Go ("Mr. B. Go") clarified if the issues were all dependencies. Ms. Aglubat answered that these were related to performance issues such as migrating PCCs to eMedcore+. Since some of the PCCs migrated to eMedcore+, there were performance issues reported as there were cited experiences of slowness for eMedcore+.

Mr. A. Go emphasized that the focus is to move forward.

Ms. Go suggested that for the reporting, a hyperlink may be used for the updates for each project. With this way, the team can see which projects were not on track and assess how to get these back on the trajectory.

Ms. Victoria responded that they would update this report with hyperlinks starting from Slide 66.

Ms. Go likewise reiterated to show the milestones per entity in MaxiGroup.

Ms. Aglubat next reported that the had already been cancelled. Mr. A. Go inquired as to the reason why.

Ms. Aglubat explained that there were development efforts for a period of ten months for However, there was a performance bottleneck during the testing. Then, ECS mentioned that they wanted additional seven months to complete the

Mr. A. Go suggested to get a second opinion on the matter. He sought confirmation that the reason why was cancelled was because of the additional seven months period.

Ms. Aglubat further reported that there were limitations in the activity because there were already 2,000+ plus calendared activities. Thus, there were already limitations to integrate within the system.

Mr. A. Go then asked the strategy and next steps to move forward. Mr. Argos explained that evaluations were still being made to determine the strategy, and that they will have to revert with their recommendations on what will replace the . As of date, the situation reverted to status quo, and that the current process will be used.

Ms. Lopez likewise added that part of the issue was the Acquity replacement since there was no enterprise version of Acquity. She emphasized the need of having their own calendar system, that will be more robust than Acquity. When ECS was asked how long it would take, they quoted that it would take around six months for development.

Ms. Go raised that there were choices in the calendar system. However, Ms. Lopez explained that were 34 clinics in production, and the doctors totaled to more than 1,000. The ultrasound schedule, and 2D Echo also totaled to around 1,800 calendars. It was explained that the calendars could no longer be expanded, and that the maximum totaled to only 2,000 calendars.

Mr. A. Go asked if a Singaporean provider may be tapped.

From a healthcare perspective, Mr. Argos discussed that there were a lot of PHRs and EMRs in the clinic operation systems which were already integrated because the queueing and scheduling were automated, and the calendar was integrated.

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Mr. Argos further committed to come up with a timetable showing the dates as to when the evaluation would be completed. He noted that they would accelerate this matter. He shared that said they cannot assist in this matter and hence, they were dropped from this particular initiative.

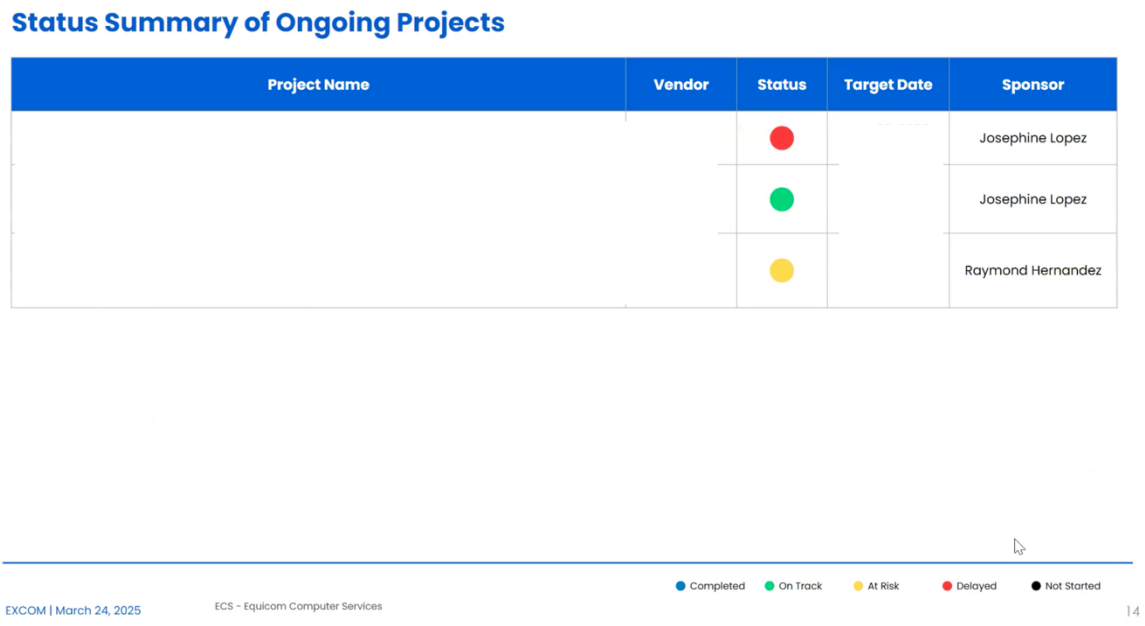
Mr. A. Go emphasized the importance of the and inquired as to what would be used in the interim, rather than to wait for a certain number of months.

Mr. Argos noted that a determination should be made on developing an integrated solution rather than pinpoint solutions.

Mr. Argos likewise raised that another reason as to why the was cancelled, was to divert and accelerate those items that would be useful.

Mr. A. Go emphasized the importance of and that it should not be cancelled.

As to the FHIR, Mr. A. Go noted that this was a common protocol and that the timelines as stated in the slide were fine. Ms. Aglubat reported on the applications as follows:



She reported that the Application was the HR system of MHSI. It required enhancements to allow the doctors to upload their receipts, and to allow the viewing of their profiles and schedules.

Mr. A. Go inquired as to whether was already integrated in the system, which was subsequently confirmed.

Mr. Argos discussed that there would have to be a redesigning of the entire clinic to have a cashier, and LGU tax reporting. There were so many cited issues once revenue was accepted for a particular site. The goal was to simplify the process in a digital way. Ms. Lopez explained that revenue was not declared per branch.

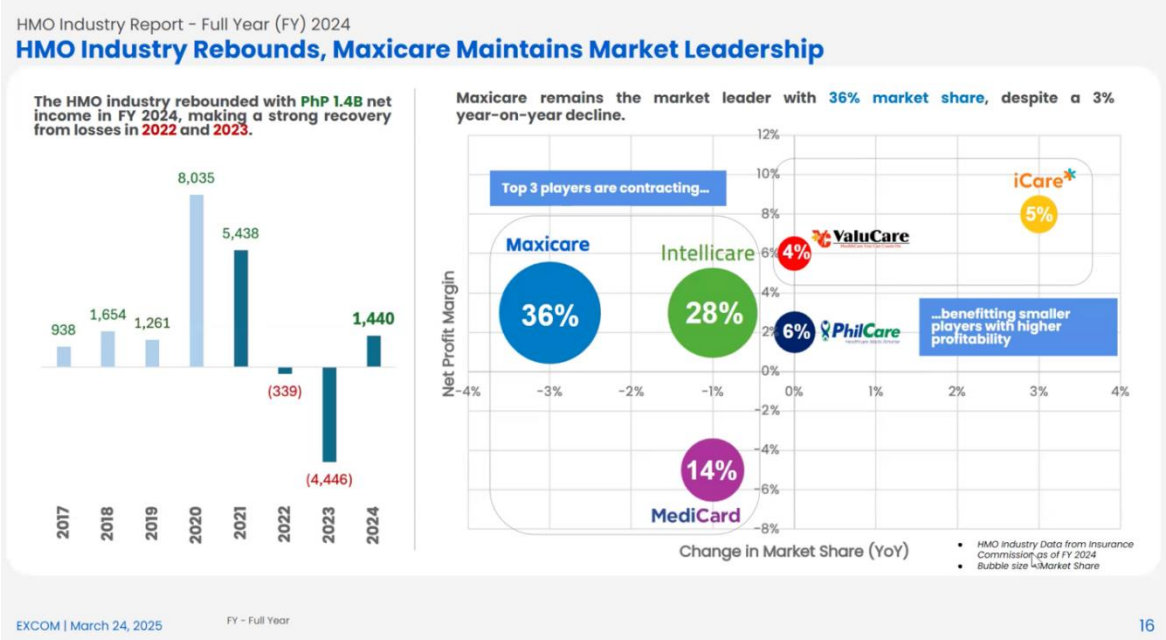
Mr. Argos further explained that there have been past challenges with a hybrid setup (full-risk and ASO). There remained a big gap as to what should be part of the benefits as owners, and what should be charged as out of pocket. He mentioned that all of the enhancements should be defined.

Mr. A. Go remarked that he was interested in the tax implications involved. He mentioned that if they can afford the taxes, why not push through with initiatives for the sake of customer convenience.

Mr. Argos added that these were priority projects and that the launch of the B2B products was critical.

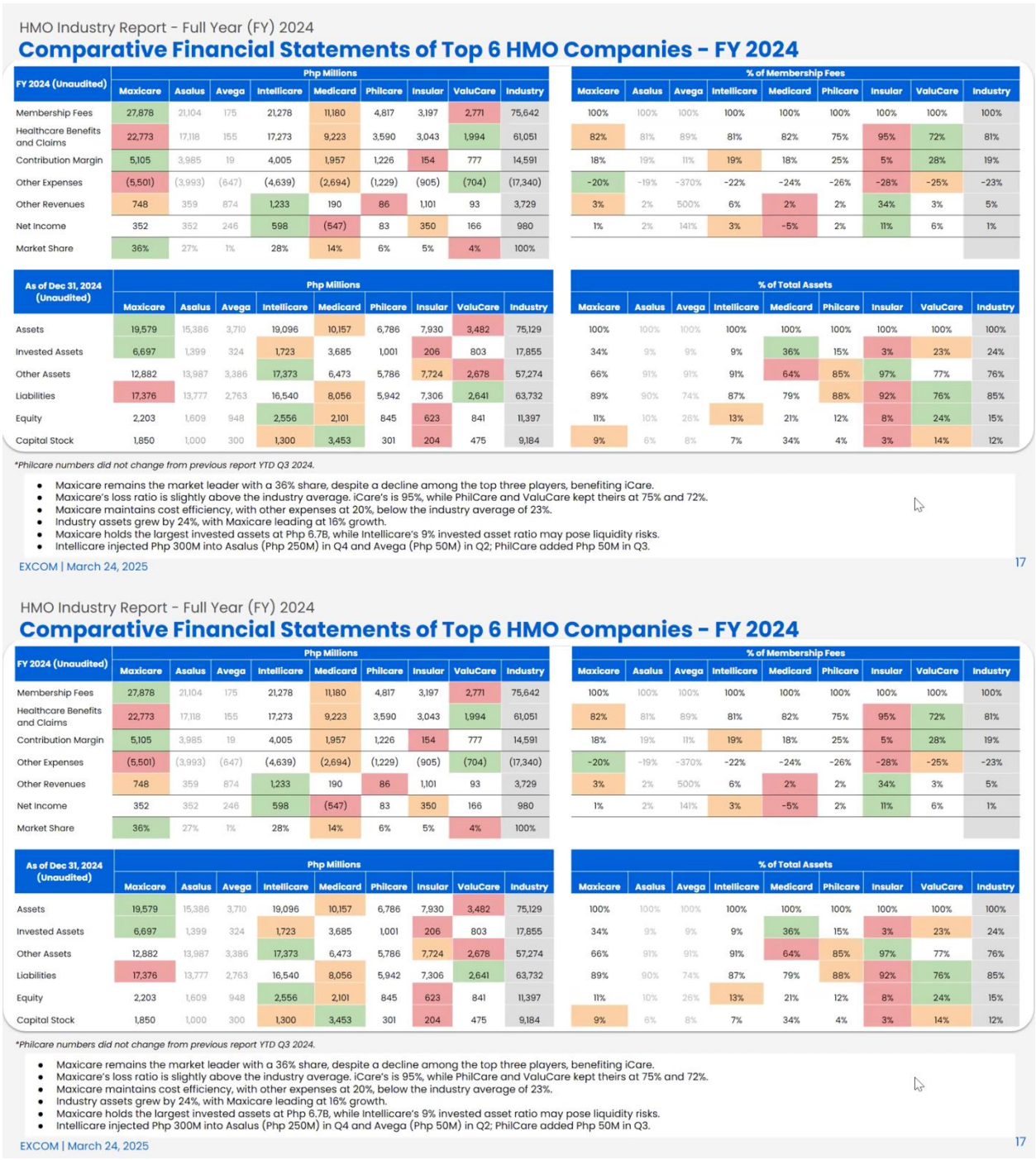
V. HMO INDUSTRY REPORT

Mr. Jerry Perez ("Mr. Perez") reported on the unaudited financial reports for the HMOs as follows:



The HMO industry rebounded, reporting a net income of Php 1.4 Billion, which was a significant turnaround from the losses incurred in 2022 and 2023. This indicated a return to the pre-pandemic profitability levels. Maxicare remained to be the market leader with 36% market share despite a -3% decline year-on-year. It was noted that iCare approximately had a 3% gain.

The financial statements of the top six HMO companies FY 2024, including the industry report were further presented as follows:



HMO Industry Report - Full Year (FY) 2024

Comparative Financial Statements of Top 6 HMO Companies - FY 2024

FY 2024 (Unaudited)	Php Millions								
	Maxicare	Asalus	Avega	Intellicare	Medicard	Philcare	Insular	ValuCare	Industry
Membership Fees	27,878	21,104	175	21,278	11,180	4,817	3,197	2,771	75,642
Healthcare Benefits and Claims	22,773	17,118	155	17,273	9,223	3,590	3,043	1,994	61,051
Contribution Margin	5,105	3,985	19	4,005	1,957	1,226	154	777	14,591
Other Expenses	(5,501)	(3,993)	(647)	(4,639)	(2,694)	(1,229)	(905)	(704)	(17,340)
Other Revenues	748	359	874	1,233	190	86	1,101	93	3,729
Net Income	352	352	246	598	(547)	83	350	166	980
Market Share	36%	27%	1%	28%	14%	6%	5%	4%	100%

	% of Membership Fees								
	Maxicare	Asalus	Avega	Intellicare	Medicard	Philcare	Insular	ValuCare	Industry
Membership Fees	100%	100%	100%	100%	100%	100%	100%	100%	100%
Healthcare Benefits and Claims	82%	81%	89%	81%	82%	75%	95%	72%	81%
Contribution Margin	18%	19%	11%	19%	18%	25%	5%	28%	19%
Other Expenses	-20%	-19%	-370%	-22%	-24%	-26%	-28%	-25%	-23%
Other Revenues	3%	2%	500%	6%	2%	2%	34%	3%	5%
Net Income	1%	2%	141%	3%	-5%	2%	11%	6%	1%

As of Dec 31, 2024 (Unaudited)	Php Millions								
	Maxicare	Asalus	Avega	Intellicare	Medicard	Philcare	Insular	ValuCare	Industry
Assets	19,579	15,386	3,710	19,096	10,157	6,786	7,930	3,482	75,129
Invested Assets	6,697	1,399	324	1,723	3,685	1,001	206	803	17,855
Other Assets	12,882	13,987	3,386	17,373	6,473	5,786	7,724	2,678	57,274
Liabilities	17,376	13,777	2,763	16,540	8,056	5,942	7,306	2,641	63,732
Equity	2,203	1,609	948	2,556	2,101	845	623	841	11,397
Capital Stock	1,850	1,000	300	1,300	3,453	301	204	475	9,184

	% of Total Assets								
	Maxicare	Asalus	Avega	Intellicare	Medicard	Philcare	Insular	ValuCare	Industry
Assets	100%	100%	100%	100%	100%	100%	100%	100%	100%
Invested Assets	34%	9%	9%	9%	36%	15%	3%	23%	24%
Other Assets	66%	91%	91%	91%	64%	85%	97%	77%	76%
Liabilities	89%	90%	74%	87%	79%	88%	92%	76%	85%
Equity	11%	10%	26%	13%	21%	12%	8%	24%	15%
Capital Stock	9%	6%	8%	7%	34%	4%	3%	14%	12%

*Philcare numbers did not change from previous report YTD Q3 2024.

- Maxicare remains the market leader with a 36% share, despite a decline among the top three players, benefiting iCare.
- Maxicare's loss ratio is slightly above the industry average. iCare's is 95%, while PhilCare and ValuCare kept theirs at 75% and 72%.
- Maxicare maintains cost efficiency, with other expenses at 20%, below the industry average of 23%.
- Industry assets grew by 24%, with Maxicare leading at 16% growth.
- Maxicare holds the largest invested assets at Php 6.7B, while Intellicare's 9% invested asset ratio may pose liquidity risks.
- Intellicare injected Php 300M into Asalus (Php 250M) in Q4 and Avega (Php 50M) in Q2; PhilCare added Php 50M in Q3.

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HMO Industry Report - Full Year (FY) 2024

Comparative Financial Statements of Top 6 HMO Companies - FY 2024

FY 2024 (Unaudited) | Php Millions | Maxicare | Asalus | Avega | Intellicare | Medicard | Philcare | Insular | ValuCare | Industry
Membership Fees | 27,878 | 21,104 | 175 | 21,278 | 11,180 | 4,817 | 3,197 | 2,771 | 75,642
Healthcare Benefits and Claims | 22,773 | 17,118 | 155 | 17,273 | 9,223 | 3,590 | 3,043 | 1,994 | 61,051
Contribution Margin | 5,105 | 3,985 | 19 | 4,005 | 1,957 | 1,226 | 154 | 777 | 14,591
Other Expenses | (5,501) | (3,993) | (647) | (4,639) | (2,694) | (1,229) | (905) | (704) | (17,340)
Other Revenues | 748 | 359 | 874 | 1,233 | 190 | 86 | 1,101 | 93 | 3,729
Net Income | 352 | 352 | 246 | 598 | (547) | 83 | 350 | 166 | 980
Market Share | 36% | 27% | 1% | 28% | 14% | 6% | 5% | 4% | 100%

% of Membership Fees | Maxicare | Asalus | Avega | Intellicare | Medicard | Philcare | Insular | ValuCare | Industry
Membership Fees | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100%
Healthcare Benefits and Claims | 82% | 81% | 89% | 81% | 82% | 75% | 95% | 72% | 81%
Contribution Margin | 18% | 19% | 11% | 19% | 18% | 25% | 5% | 28% | 19%
Other Expenses | -20% | -19% | -370% | -22% | -24% | -26% | -28% | -25% | -23%
Other Revenues | 3% | 2% | 500% | 6% | 2% | 2% | 34% | 3% | 5%
Net Income | 1% | 2% | 141% | 3% | -5% | 2% | 11% | 6% | 1%

As of Dec 31, 2024 (Unaudited) | Php Millions | Maxicare | Asalus | Avega | Intellicare | Medicard | Philcare | Insular | ValuCare | Industry
Assets | 19,579 | 15,386 | 3,710 | 19,096 | 10,157 | 6,786 | 7,930 | 3,482 | 75,129
Invested Assets | 6,697 | 1,399 | 324 | 1,723 | 3,685 | 1,001 | 206 | 803 | 17,855
Other Assets | 12,882 | 13,987 | 3,386 | 17,373 | 6,473 | 5,786 | 7,724 | 2,678 | 57,274
Liabilities | 17,376 | 13,777 | 2,763 | 16,540 | 8,056 | 5,942 | 7,306 | 2,641 | 63,732
Equity | 2,203 | 1,609 | 948 | 2,556 | 2,101 | 845 | 623 | 841 | 11,397
Capital Stock | 1,850 | 1,000 | 300 | 1,300 | 3,453 | 301 | 204 | 475 | 9,184

% of Total Assets | Maxicare | Asalus | Avega | Intellicare | Medicard | Philcare | Insular | ValuCare | Industry
Assets | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100%
Invested Assets | 34% | 9% | 9% | 9% | 36% | 15% | 3% | 23% | 24%
Other Assets | 66% | 91% | 91% | 91% | 64% | 85% | 97% | 77% | 76%
Liabilities | 89% | 90% | 74% | 87% | 79% | 88% | 92% | 76% | 85%
Equity | 11% | 10% | 26% | 13% | 21% | 12% | 8% | 24% | 15%
Capital Stock | 9% | 6% | 8% | 7% | 34% | 4% | 3% | 14% | 12%

*Philcare numbers did not change from previous report YTD Q3 2024.

- Maxicare remains the market leader with a 36% share, despite a decline among the top three players, benefiting iCare.
- Maxicare's loss ratio is slightly above the industry average. iCare's is 95%, while PhilCare and ValuCare kept theirs at 75% and 72%.
- Maxicare maintains cost efficiency, with other expenses at 20%, below the industry average of 23%.
- Industry assets grew by 24%, with Maxicare leading at 16% growth.
- Maxicare holds the largest invested assets at Php 6.7B, while Intellicare's 9% invested asset ratio may pose liquidity risks.
- Intellicare injected Php 300M into Asalus (Php 250M) in Q4 and Avega (Php 50M) in Q2; PhilCare added Php 50M in Q3.

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Maxicare had a net income of Php 352 Million, which was 1% of the target with BCG fees already included. If the BCG fees would be included net of tax, the net income would range to around Php 8 Million to Php 12 Million, close to the original budget of Php 18 Millon net income.

Mr. Perez further reported that the loss ratio was slightly above the industry average which was at 82%. The ratio for the industry average was at 81%.

The loss ratio of iCare was significantly high at 95%. On the other hand, Philcare and Valucare contained their loss ratios at 75% and 72%, respectively.

As a whole, the industry increased its loss ratio by 5% from 85.4% to 80.7%. Maxicare demonstrated sufficiency with other expenses at 20% (excluding BCG fees at 18%), which was well below the industry average of 23%. The 23% industry average marked a slight decrease from 24% in the previous years. In addition, the total assets grew by 24%, leading to at least a 60% increase in Maxicare.

Maxicare was noted to hold the largest invested asset at Php 6.7 Billion in contrast to Intellicare's invested asset ratio for 9% of its total assets, which indicated potential liquidity challenges.

Moreover, Intellicare infused Php 250 Million into Asalus and Php 50 Million in Avega during the fourth and soecond quarters, respectively. Philcare infused additional Php 50 Million in the third quarter.

Mr. Argos reported that Intellicare was meeting the financial ratios and the capital cash infusion could possibly indicate liquidity, which meant that good ratios were being shown. Philcare similarly showed good profitability and good loss ratios, but they need additional cash.

Mr. Argos noted that Php 300 Million went into Intellicare while Php 50 Million went into Philcare. Intellicare and Philcare were really profitable, but iCare presented a curious case because they have a high loss ratio of 95%. Their other revenue was still at Php 1.1 Billion, but such figure did not grow and was deemed as a non-recurring item by Mr. Perez.

Mr. Perez explained that the Php 874 Million came from the ASO[8] business. Mr. Argos inquired whether there were claims processing. Mr. Perez confirmed that Avega also had claims processing, which included discounts to providers.

Mr. Perez discussed that there was a cross charging of Php 100 Million from Asalus to Avega, but the services were not at that rate hence, the numbers were a bit inflated.

Mr. Rene Buenaventura ("Mr. Buenaventura") asked what particular agency was referred to by the IC when they announced the migration of supervision over HMOs to another government agency.

Mr. Argos explained that it would probably be a new agency, and not the IC. The leading proposal was a new regulatory body, which was the Center for Managed Care attached to the

[8] ASO: Administrative Services Only.

Department of Health. Commissioner Reynaldo Averilla Regalado made that statement because he did not want to be perceived as being opposed or not on board with the move to migrate.

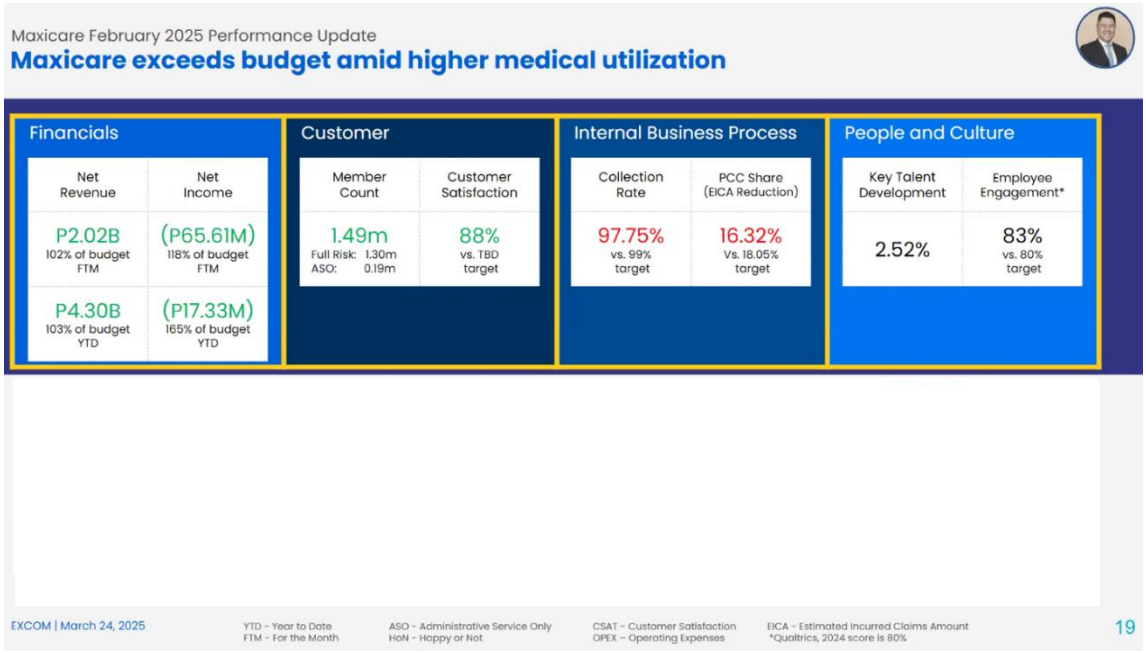
In the USA, it was explained that HMOs were supervised by the IC.

It was likewise clarified that it was not the IC which initiated this proposed migration of regulatory supervision.

VI. FEBRUARY FINANCIAL & SALES PERFORMANCE

Financial Performance

Mr. Argos reported that February 2025 was a good month for Maxicare. From a revenue perspective, he explained that the main highlight was that they were slightly ahead of their plans. More success was observed in respect of managing Non-Renewals.



EICA and MUC were higher and offset by higher efficiencies. The collection rate was at 97.75%, which was a timing issue. Mr. Argos reported that they were actually at 98.9%, and that was because the first quarter of the year had the biggest billing period. Clients would be paying by February and March, and the cash balance was expected to increase by the end of March or April.

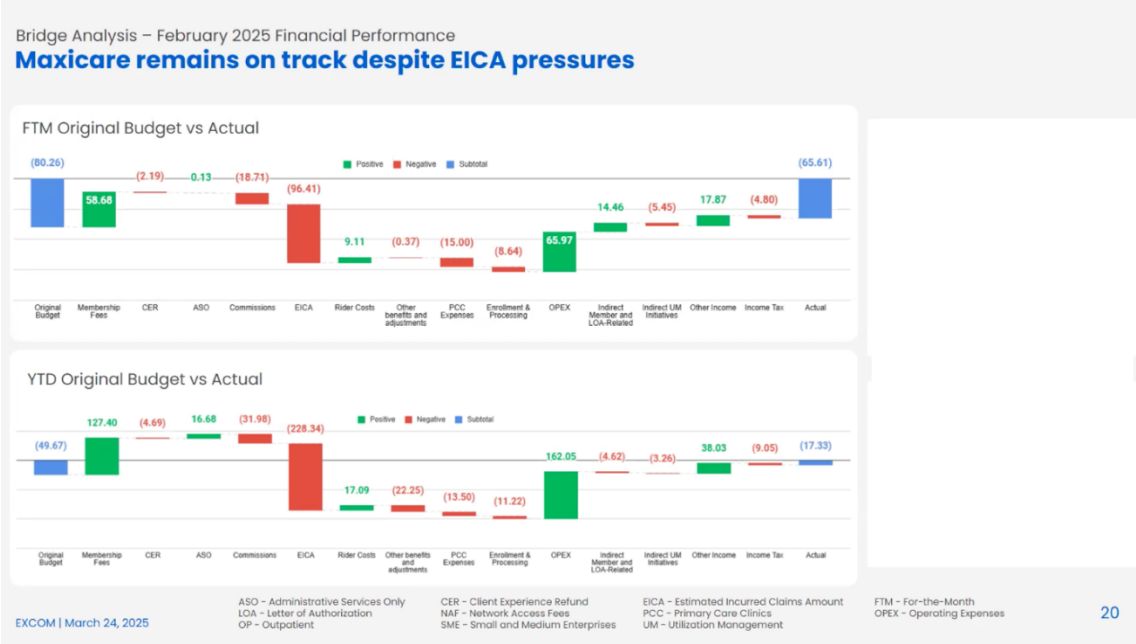
It was confirmed that such rates were minor issues because the first 3 months usually showed a lower collection ratio.

Mr. A. Go instructed that figures reflecting the uncollectible items should likewise be reported.

In relation to this, Mr. Perez noted that Maxicare had allowance for doubtful accounts ("ADA").

Mr. A. Go reported that the method on how to maximize Net Operation Loss Carry Over ("NOLCO") should also be presented.

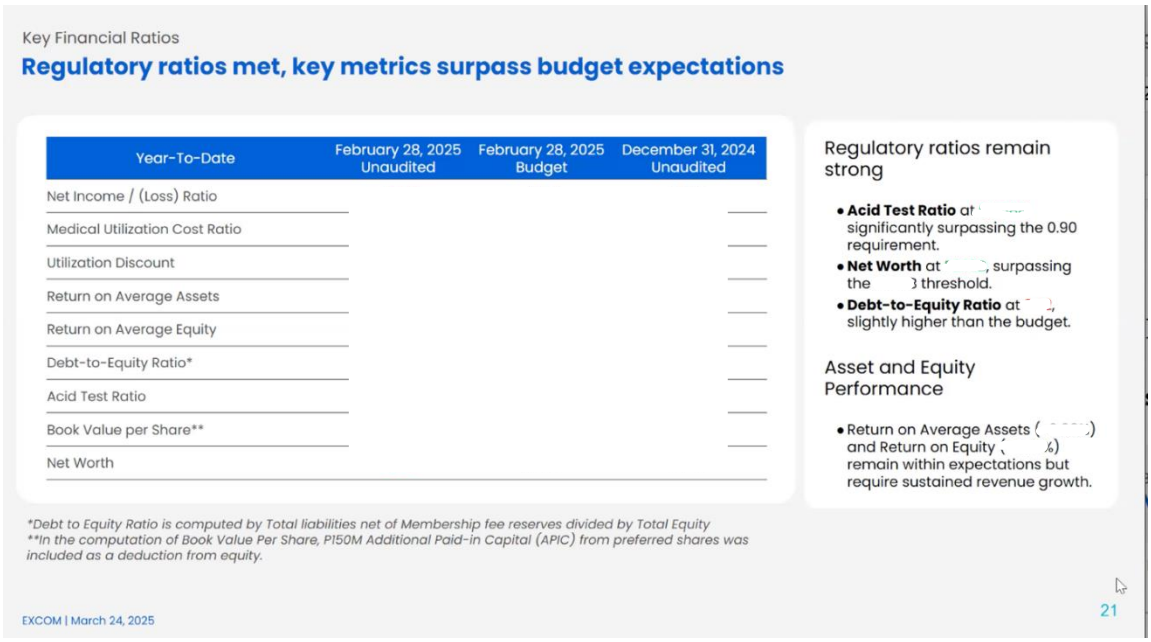
As to the financial performance, Mr. Jasper Cheng ("Mr. Cheng") reported as follows:



Mr. Gokongwei asked how the EICA was projected for March. Mr. Perez answered that the trend was still similar as in February.

Mr. B. Go inquired for accounting purposes, if the BCG fees had already been recorded last year. Mr. Cheng responded that around 80-90% had been reported last year. Mr. Argos added that the computation was based on the CM hitting the Profit and Loss ("P&L"). This was not yet in the P&L but was already part of the budget.

Mr. Cheng continued with the report. He mentioned that the membership fees and EICA were higher. He also reported that regulatory ratios were met, and the key metrics surpassed budget expectations:



Key Financial Ratios

Regulatory ratios met, key metrics surpass budget expectations

Year-To-Date	February 28, 2025 Unaudited	February 28, 2025 Budget	December 31, 2024 Unaudited
Net Income / (Loss) Ratio			
Medical Utilization Cost Ratio			
Utilization Discount			
Return on Average Assets			
Return on Average Equity			
Debt-to-Equity Ratio*			
Acid Test Ratio			
Book Value per Share**			
Net Worth			

Regulatory ratios remain strong

- **Acid Test Ratio** at significantly surpassing the 0.90 requirement.
- **Net Worth** at , surpassing the threshold.
- **Debt-to-Equity Ratio** at slightly higher than the budget.

Asset and Equity Performance

- Return on Average Assets ( ) and Return on Equity (%) remain within expectations but require sustained revenue growth.

*Debt to Equity Ratio is computed by Total liabilities net of Membership fee reserves divided by Total Equity
**In the computation of Book Value Per Share, P150M Additional Paid-in Capital (APIC) from preferred shares was included as a deduction from equity.

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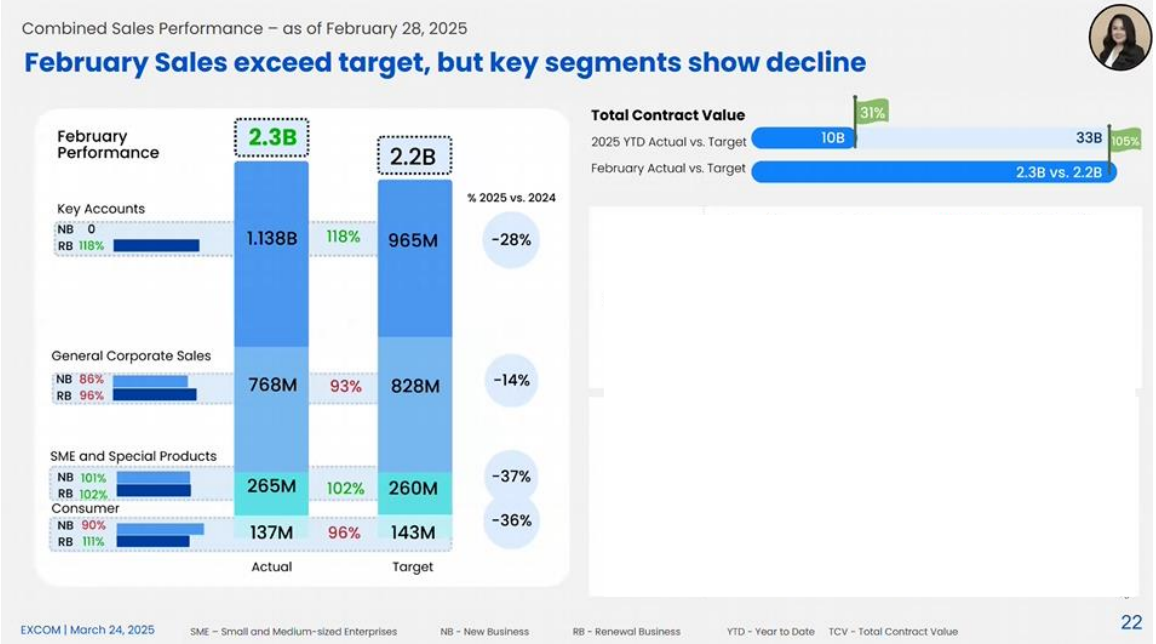
With regard to the Acid Test Ratio, he noted that there was some discussion in the IC that the formula would be changed. Should this be the case, the new formula would benefit Maxicare since the denominator would be decreased (to exclude movement on factors such as the unearned fees, IBNR[9] and MfAD[10] and the estimate was that the Corporation would be

As per Mr. B. Go's query on how to decrease laboratory costs, discussions were made on increasing steerage to the PCCs and the significance of the .

Sales Performance

[9] IBNR: Incurred But Not Reported.
[10] MfAD: Margin for Adverse Deviation.



Ms. Victoria presented the sales performance for the month of February. The Overall Revenue Performance was at 105% for SME & Special Products, General Corporate, Key Accounts, and Consumer Sales; with a total combined TD of 89%, and 30% vs. Annual Target.

The key accounts driving the excess showed a 117.89% performance. The SMEs outperformed the target for January and February versus the increase in the 2024 performance at 125% achievement. The general corporate sales and consumers (individuals and families) were short of its February target at 93% and 96% respectively.

For the month of February, the total renewals of the business across all units which include the corporate and consumer segments were at 118%, while new businesses were behind by 10% with a 59% achievement versus target.

The YTD figures for January and February combined targets both new and renew business were short by 13%, with a performance of 87% across all channels. The shortfall was a result of the non-renewals in January 2025.

Mr. A. Go asked about the competitive gains and losses and Ms. Victoria answered that this would be included in the annex. She reported that the highest gain would be from Intellicare. She mentioned that Maxicare would highlight aggressive acquisition for new contracts and covering the non-renewals from last year. The Corporation would also push for the launch of new products in the Q3 and Q4.

Mr. A. Go mentioned that moving forward, this should be included in the main report and not just in the annex.

Mr. Gokongwei inquired on the 2025 projection for membership headcount. Ms. Victoria responded that the original target was

Ms. Victoria noted that they were able to close , which was the biggest win of the month. This came from Intellicare although they already had the agent for 6 years, effectively surpassing the DNRs. The estimated contract value was at

The CM target remained at 18%. New business closed was approximately 26%. The key accounts were priced at an average of 16% though these delivered the excess on PCC performance by 8%.

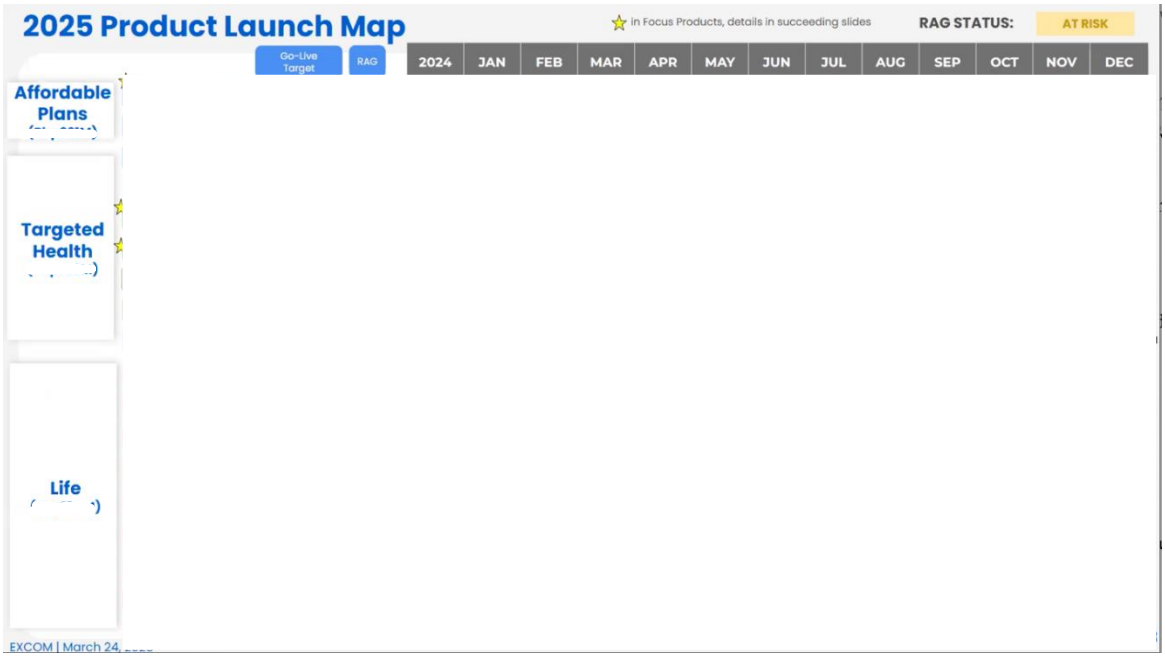
For the new business per capita, the current pricing was at per member. For renewal, the current per capita was at , per member, although the non-renewals for the month of February were at an average of per head, which was lower by 26% from the existing membership rates.

For the channels and corporate accounts, both general corporate and key accounts were still driven by brokers with 70% of the BCG direct accounts at 18% and 8%, respectively, for the agents. However, for the SME and special products, these were still heavily driven by the agents' performance at 67%, with direct sales channels at 23%.

The consumer accounts, individual, and family segments represent 51% with the agents and followed by the purchases from the Maxicare online store at 27%.

VII. OGSM INITIATIVES

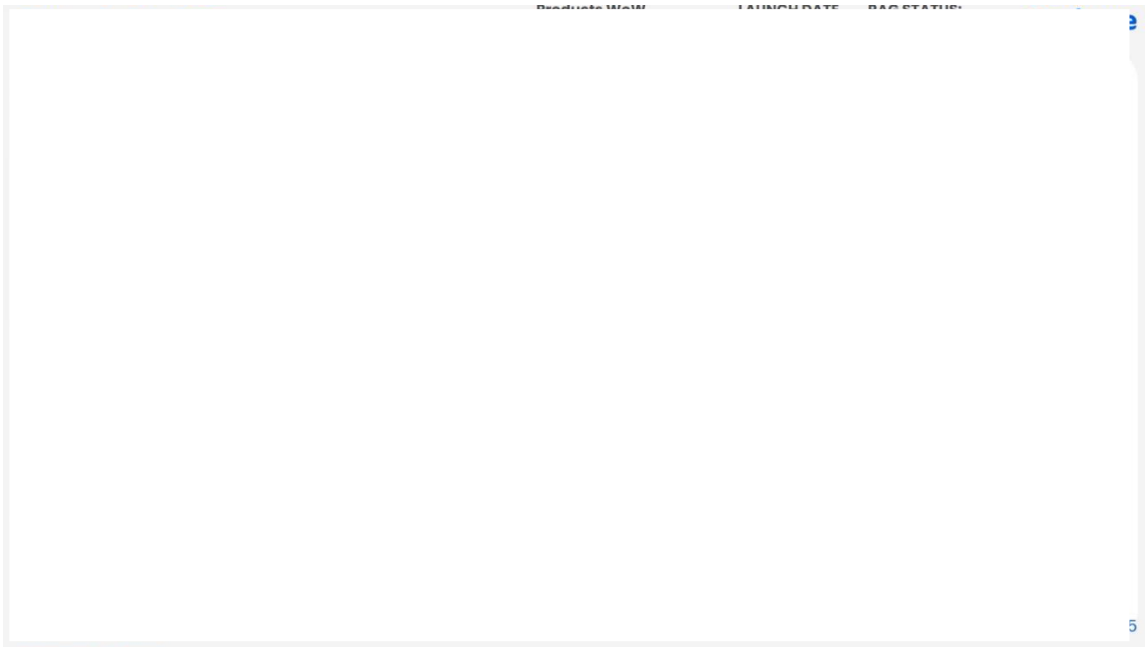
Mr. Raymond Hernandez ("Mr. Hernandez") started his report with the product roadmap which was presented as follows:



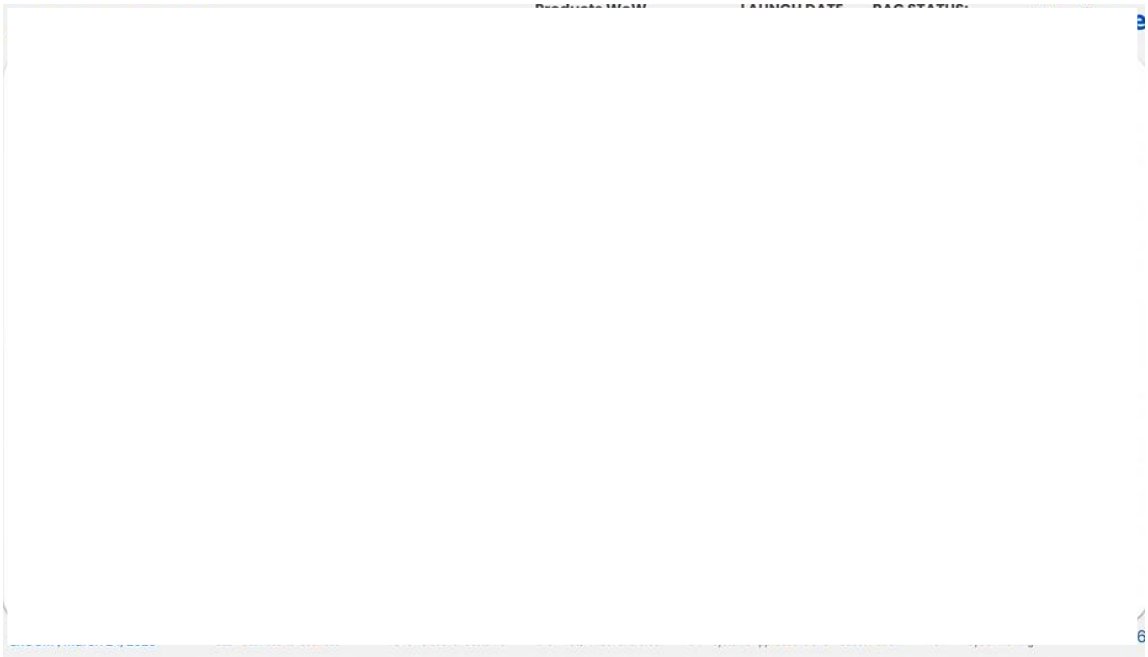
Mr. Hernandez noted that the lower part of the above presented diagram showed the products which were at risk. He emphasized the need to focus on the bigger products at this point.

He then reported on the products under Afforable B2B:

He discussed that the affordable B2B plans would be as low as with up tc coverage critical illness, access to 2,000 hospitals, and addresses 90% of the employees.



He discussed that the these were described as a stack product applicable to Maxicare, MaxiHealth, and MaxiLife.



Currently, there have been approvals for minimum 3 principals per plan and the corporate commission scheme was approved already.

The following were the next steps that must be undertaken to be able to reach the April launch:

It was clarified that the above is a full-risk plan.

In response to Mr. B. Go's question, Ms. Victoria explained that the product could be channel specific. For instance, the coverage will cover the emergency room which could involve up to per year. For procedures, the product could also be specific in the sense that it would cover only chemotherapy of up to 3 sessions.

Mr. Argos explained that there were clear rules of engagement as they do not want to cannibalize the existing full-risk. The way the plan was structured was that the headline number was the ABL[11] with a number of on the rider side. There was also product stacking and how these could affect the critical illness. He explained that the cost was managed in that manner.

To give more context, Mr. Hernandez explained that for the budget variant, since there were variants and some sub variants per category, there was per category. When launched or , it will already be standard and comprehensive because will be utilized for the budget.

For MaxiLife, there were covering 3 critical illness. The stacking of the different services for the different operations enabled the decrease in risk.

There was also regional pricing for Luzon, Visayas and Mindanao.

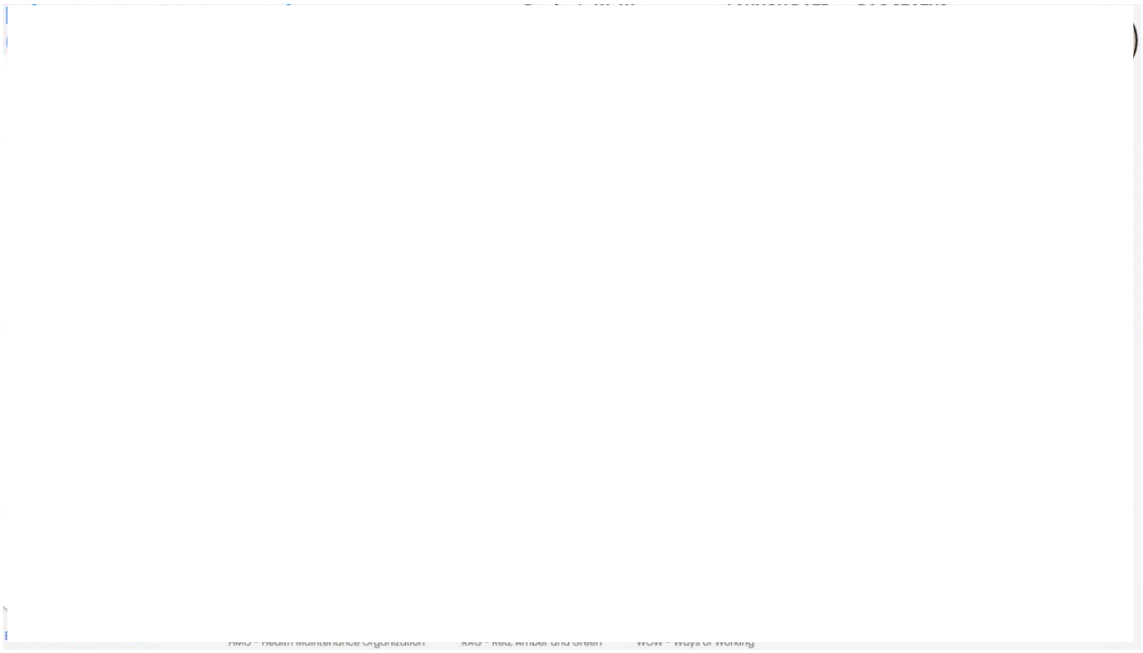
The different strategies to potentially address the risk of those not renewing have likewise been formulated. Further, priority key accounts that can still be built back with the product of around 20% minimum price of have been identified. All will be member-initiated LOA.

Ms. Victoria discussed that the target accounts for new businesses were accounts of iCare and Valucare. For renewals, the target accounts were

Mr. A. Go emphasized the need to automate the entire process. Mr. A. Go tasked Mr. Hernandez to estimate the cost of such automation and the cost of delay.

[11] ABL: Annual Benefit Limit.

Moving forward, the B2C plan in relation to ACU and ECU Meds was presented as follows:



The focus areas were identified as follows:

1. Immediate Access
- Serving individuals without HMO coverage and their dependents

2. Affordable Screening Packages
- Targeting the out-of-pocket market for prevention and early detection

3. Beyond Screening
- Enhancing health support with medicine programs, wellness/lifestyle packages, and opportunities to scale MaxiGroup prepaid products.

Through intermarket analysis, the areas identified for growth and opportunities were presented as follows:

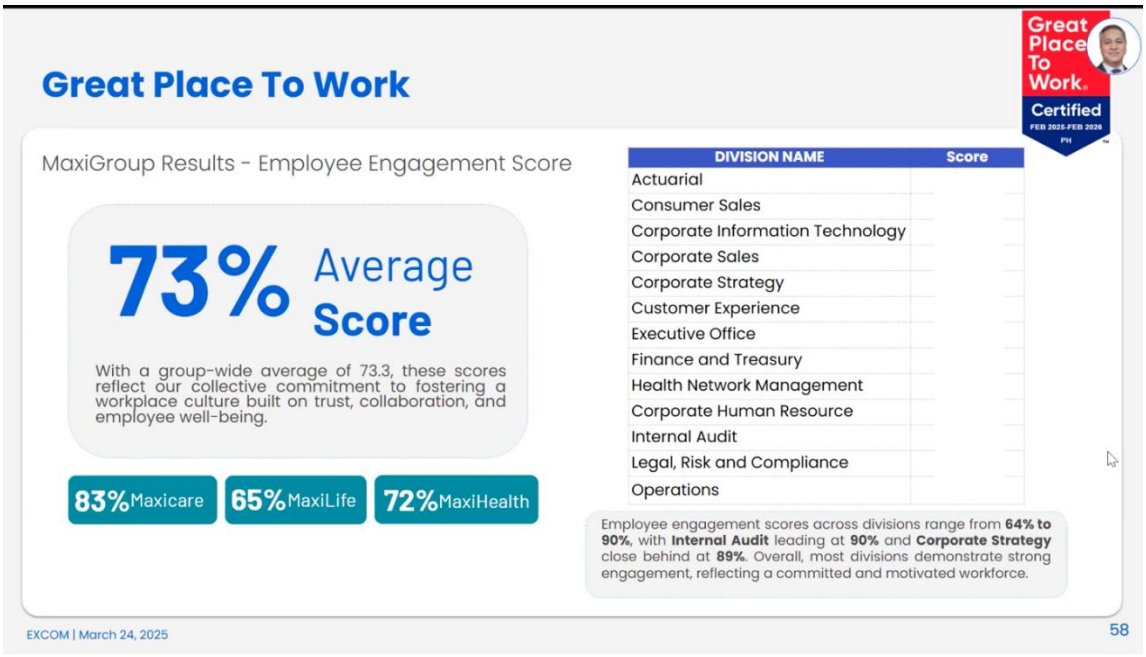
The product design was further presented as follows:

Mr. Hernandez noted that the prices were merely indicative and were yet to be finalized.

Mr. Argos noted that this followed the Prima model and recognized that in the HMO side, members go to a hospital and ask if certain tests could be added. Afterwards, the member asks for an LOA which goes into the loss ratio. After shifting to the Prima products, the

revenue will be captured as revenue-generating and income-generating as opposed to just an expense under full-risk.

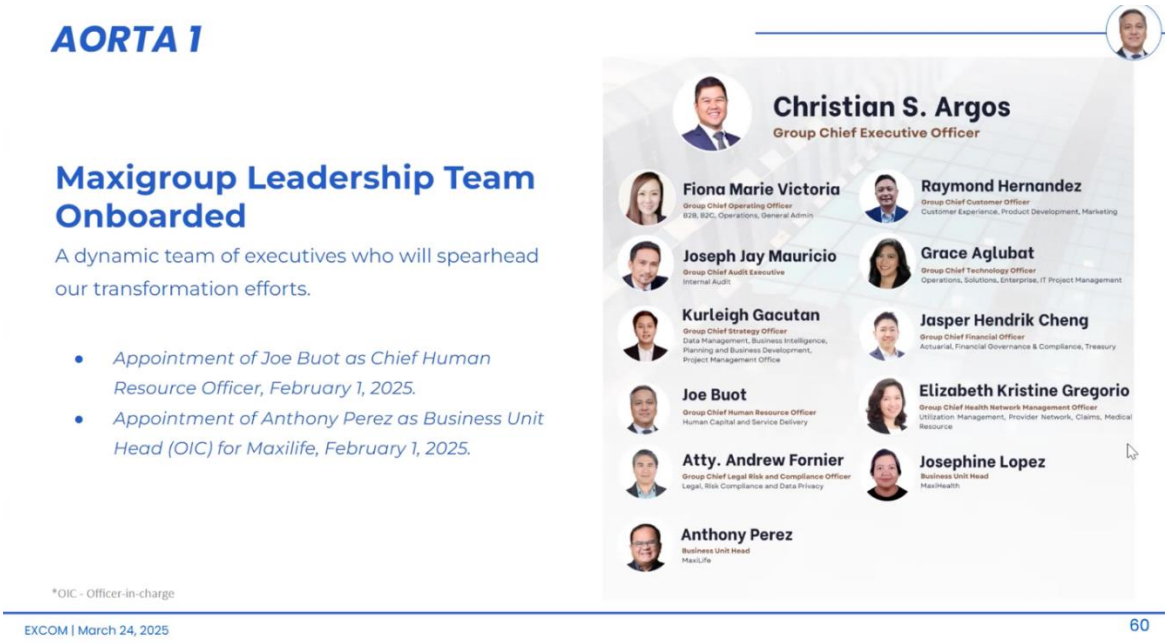
As to the organizational transformation, Mr. Joe Buot ("Mr. Buot") explained employee engagement score for the results of MaxiGroup:



The average score for the whole group was at 73% with business unit performance rates of 83% for Maxicare, 65% for MaxiLife, and 72% for MaxiHealth.

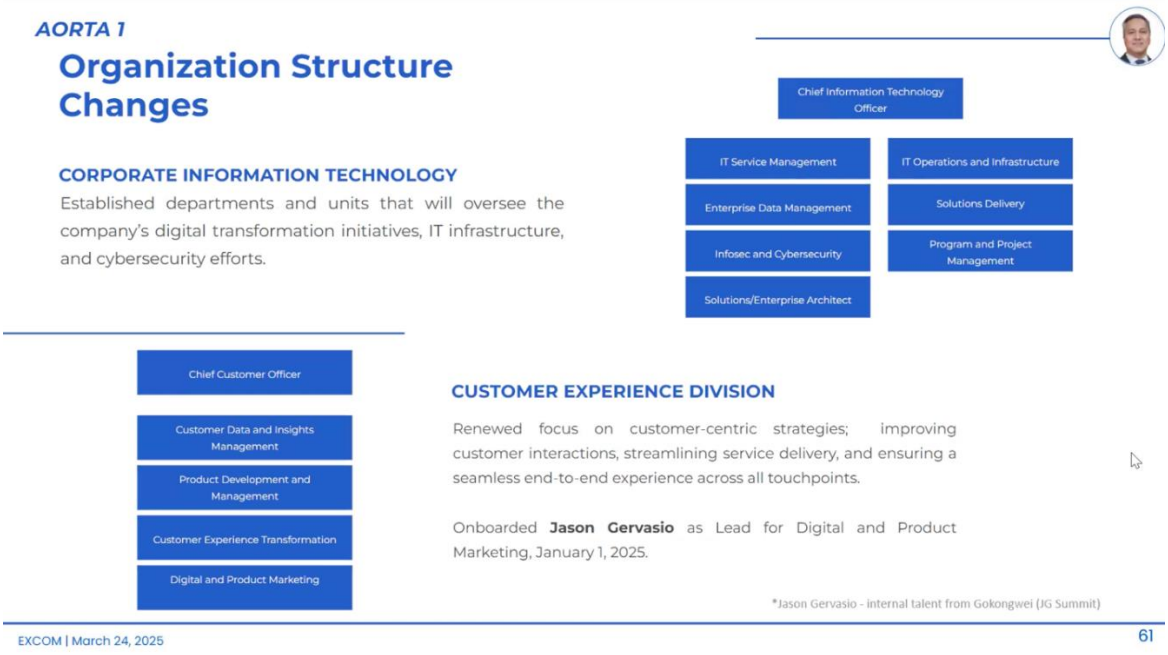
Mr. A. Go raised the topic on how Artificial Intelligence ("AI") can be used to supplement assistance while working to make outputs more efficient. Mr. Buot confirmed that they were working on personifying the same as well.

For Aorta 1, there have been leadership changes, *to wit*:



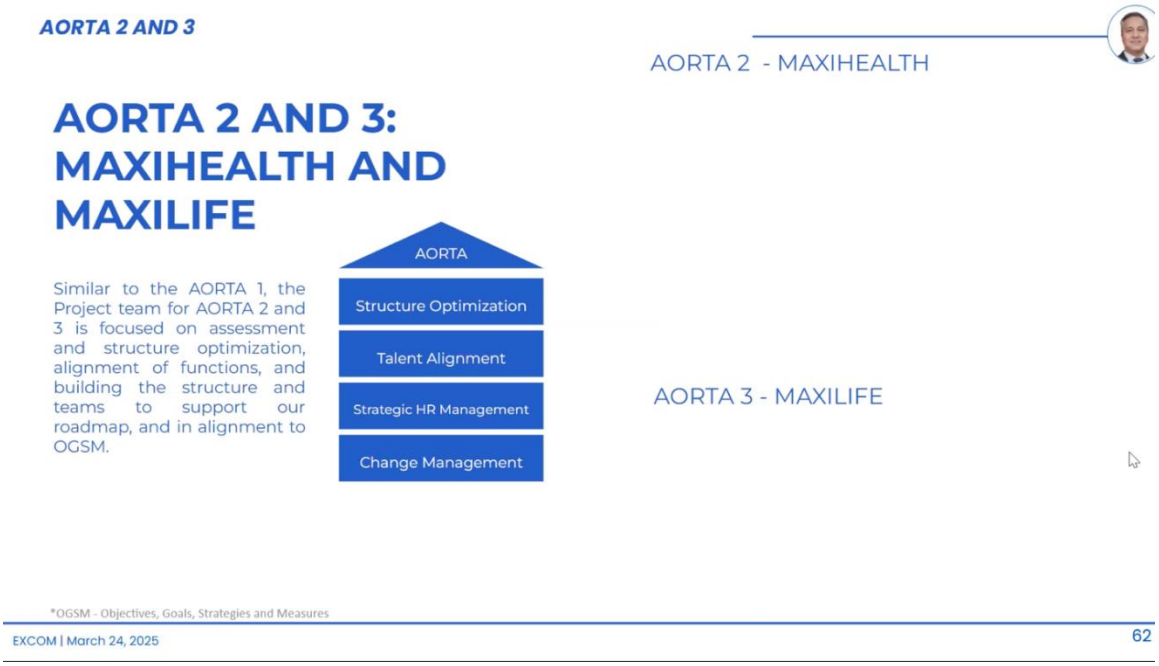
The team was reported as complete.

Mr. Buot explained that part of Aorta 1 was to take a look at completing the complement for corporate information technology by reviewing the structure and putting in the leadership individuals for the information technology group. He further reported the following:



He noted that the team was working on a digital organization as well.

For Aorta 2 and 3, a similar structure will be done for MaxiHealth and MaxiLife, along with the associated timeline, to wit:



VIII. ADJOURNMENT

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

Prepared by:

ATTY. DANNY E. BUNYI
Corporate Secretary

Attested by:

LANCE Y. GOKONGWEI **ANTONIO L. GO**

BRIAN M. GO **ESTHER WILEEN S. GO**

ROBERTO J. MACASAET, JR. **RENE J. BUENAVENTURA**

MICHAEL P. LIWANAG