2024 ANNUAL REPORT

OPTIMUM MEDICAL AND HEALTHCARE SERVICES INC.
2024 Annual Report

A. OVERVIEW

ABOUT OPTIMUM MEDICAL AND HEALTHCARE SERVICES, INC.

Optimum Medical and Healthcare Services Inc. (the "Company") was incorporated in the Philippines on February 2, 2013 with the Securities and Exchange Commission (SEC) under SEC Reg. No. CS201304002. Its primary purpose is to engage in healthcare services. The Company is regulated by the Insurance Commission (IC) and was granted IC License No. HMO-2023-19-R.

The Company's principal place of business is at 705-C Atlanta Center #31 Annapolis St., Greenhills, San Juan City.

Vision Statement

Our vision is to be one of the best medical healthcare provider in the coming year.

Mission Statement

The Company commits to provide the best medical healthcare services to its clientele while maintaining financial viability. It aims to implement cost-efficient operations without sacrificing the quality of care, while ensuring continued learning and professional development for its medical and nursing staff.

The Company also seeks to institute wellness programs for its corporate clients and actively discuss and implement improvements in healthcare services in collaboration with its clientele.

Furthermore, it is committed to sustaining strong partnerships with other stakeholders and clients within the healthcare industry.

MESSAGE FROM THE PRESIDENT

DR. GERALD C. SY
MD, FPCS, FPAPRAS, MBA
President, CEO and Chairman of the Board

It is with great pride and gratitude to announce that 2024 has been a year of relentless dedication and commitment by our stockholders, officers and organizational staff to comply with all the regulatory requirements of an industry like the health maintenance organization. While the Company has not been actively involved in the production aspect over the past two years, this period has allowed for reflection, assessment and careful planning.

Looking ahead in the years to come, the Company has decided to be active with a renewed focus on strengthening our governance, operational discipline and service to our clientele. To accomplish this objective, we are in the process of finalizing agreements with carefully selected marketing partners.

As proof of our sincerity to be a driving force again in the healthcare services, we commit to comply with the requirements of IC Circular Letter 2025-11 stating among others the minimum capitalization and financial capacity requirement. In addition to this, the Company has already initiated the groundwork for the implementation of PFRS 17 as required under IC Circular Letter 2025-05 and we expect the completion of the framework by the third quarter of 2026.

The Company reaffirms our full commitment to all regulatory requirements governing the HMO industry and to uphold the highest standards of transparency, accountability and ethical practice. The years ahead will be a renewed chapter that will focus on stability, compliance, and sustainable growth as we will strive to work harder to restore confidence and deliver reliable healthcare solutions to those we will serve.

BOARD OF DIRECTORS

DR. GERALD C. SY, MD, FPCS, FPAPRAS, MBA
President, CEO and Chairman of the Board

He completed a four-year Master in Business Administration program from the Ateneo Graduate School followed by a three years of training in Plastic and Reconstructive Surgery from the Philippine General Hospital. He also underwent five years of training in general and cancer surgery from Cardinal Santos Medical Center and underwent Hepatobiliary Surgery education from Kaohsiung Medical Center. He is a Doctor of Medicine graduate of Far Eastern University and completed his medical internship at Chinese General Hospital.

DR. LARRISSA ISABEL P. BLAS, MD
Corporate Secretary and Director

She completed basic training in ultrasound surgery from the Philippine Society of Ultrasound Surgery and underwent two years of residency training in general surgery at Cardinal Santos Medical Center. She also completed a postgraduate internship at the Philippine General Hospital from 1995-1996. She is a Doctor of Medicine graduate of the University of the East Ramon Magsaysay Memorial Medical Center, class of 1995.

DR. SHERRY LIM LEE, MD.
Chief Compliance Officer and Director

She served as a resident physician in the Department of Surgery at Cardinal Santos Medical Center. She completed her Doctor of Medicine degree as well as her postgraduate internship at the University of the East Ramon Magsaysay Memorial Medical Center.

MS. BELEN CHIU
Treasurer and Director

She holds a Master in Business Administration from the Ateneo Graduate School of Business and Bachelor of Science in Math Major in Actuarial Science from the University of Santo Tomas.

MR. MARIO CHAN
Director

He holds a degree of Bachelor of Science in Architecture from the University of Santo Tomas.

DR. RENE CHAN
Independent Director

He is a graduate of Civil Aviation Medicine from the University of Melbourne, Australia and holds a Master in Business Administration in Health from the Ateneo Graduate School of Business. He works in the field of general surgery at Cardinal Santos Medical Center and completed both his Doctor of Medicine degree and medical internship at the University of Santo Tomas.

DRA. CONNIE BERNARDO
Independent Director

She holds a Master's in Business Administration – Health from the Ateneo Graduate School of Business. She is a Medicine graduate of the University of the Visayas College of Medicine and earned a Bachelor of Science in Medical Technology from Southwestern University.

FINANCIAL HIGHLIGHTS

The Company's 2024 Financial Statements presented below reflects a period in which the company did not meet the prescribed net worth requirement due to sustained net loss brought about by the absence of active business operation during the period under review.

The resulting net loss is attributable to the continued incurrence of operating and administrative expenses in the absence of premium revenue since the Company had no active operations and did not generate income from the core HMO activities. Consequently, all expenses were funded solely from existing company bank accounts that generates minimal interest and investment income from the statutory investment. As a result, retained earnings declined leading to a reduction in total equity thereby causing non-compliance with the net worth requirement as of year-end.

Management acknowledges this condition and has complied with corrective measures subsequent to the 2024 financial statement and recognizes the need for the resumption of active operations, improvement of revenue generation and capital support to strengthen the Company's financial position.

OPTIMUM MEDICAL AND HEALTHCARE SERVICES INC.
STATEMENTS OF FINANCIAL POSITION
DECEMBER 31, 2024 AND 2023
(Amounts in Philippine Peso)

	2024	2023
ASSETS		
Current Assets		
Cash	**1,960,236**	5,724,602
Treasury Bills	**5,188,647**	-
Accounts Receivable and Prepaid Expenses	**4,852,908**	6,853,908
Total Current Assets	**12,001,791**	12,578,510
Noncurrent Assets		
Property and Equipment - net	**1**	1
Total Noncurrent Assets	**1**	1
	12,001,792	12,578,511
LIABILITIES AND EQUITY		
Current and Other Liabilities		
Trade and other payables	**2,377,510**	1,075,562
Due to Insurance & Providers	**641,164**	631,724
Accrued Expenses	**156,956**	156,956
Total Liabilities	**3,175,630**	1,864,242
Equity		
Capital stock – 1 par value		
Authorized – 100,000 shares	**10,000,000**	10,000,000
Issued and subscribed-100,000 shares		
Retained earnings	**1,173,838**	714,269
Total Equity	**8,826,162**	10,714,269
	12,001,792	12,578,511

OPTIMUM MEDICAL AND HEALTHCARE SERVICES INC.
STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023
(Amounts in Philippine Peso)

	2024	2023
SERVICE REVENUES	0	0
OPERATIMG & ADMIN EXPENSES	-2,109,123	-1,046,865
GROSS PROFIT	-2,109,123	-1,046,865
INCOME BEFORE INCOME TAX	-2,109,123	-1,046,865
PROVISION FOR INCOME TAX	0	0
NET INCOME FOR THE YEAR	-2,109,123	-1,046,865
OTHER COMPREHENSIVE LOSS		
Comprehensive Income	221,015	188,619
TOTAL COMPREHENSIVE INCOME	-1,888,108	-858,246

B. LOOKING AHEAD – MARKET AND BUSINESS STRATEGY

After a period of non-activity over the past two years, the Company now looks ahead with a renewed sense of purpose and strategic clarity as it prepares to re-enter the HMO market in the coming year. The changing regulatory environment, advances in technology, and evolving healthcare needs require a more disciplined, integrated, and forward-looking approach to business operations. Recognizing these realities, the Company is committed to implementing a comprehensive market and business strategy that is anchored on sustainability, regulatory alignment and responsible growth.

This strategy is designed not only to restore market presence but to rebuild credibility and operational strength through focused initiatives in marketing, information technology, financial reporting under PFRS 17, strengthened corporate solutions, strict regulatory compliance and proactive risk management. By aligning these key areas briefly described in the succeeding section to a cohesive plan, the Company aims to re-establish itself as a compliant, resilient, and member-focused HMO, well-positioned to meet both market expectations and regulatory standards in the coming year.

MARKETING

The Company will strategically focus its operations on two core HMO product offerings: Fund Management Packages and Premium-based Packages. This product approach aims to address the varying needs and risk profiles of corporate and individual clients while maintaining operational flexibility and financial sustainability, simply described as follows:

I. The Fund Management Package is designed for corporate clients to self-fund healthcare benefits. The Company acts as administrator and healthcare manager, providing services like network access, utilization management, claims administration and reporting while medical costs are paid from a fund established and owned by the client. This approach allows clients greater control over healthcare spending and risk while the Company earns management and administrative fees without assuming direct insurance risk.

The program ensures cashless hospitalization, hassle free services, efficient and cost effective medical services. OMHSI has established systems of controlling costs and protocols to improve quality of services.

II. The Premium-Based Package provides members with defined healthcare benefits and greater cost predictability, while the Company manages utilization, provider contracts and claim payments. This package requires prudent underwriting, adequate reserves and strict compliance with regulatory requirements since the Company bears the financial risk associated with healthcare utilization.

The Company decided to continue offering both the fund management package and premium-based package in the years ahead. The decision is grounded in strategic, financial and regulatory considerations that support long-term sustainability and market relevance.

By concentrating on these two product types, the Company will be able to continue to develop specialized expertise in both healthcare fund administration and risk-bearing HMO operations. This strategy will support operational efficiency, clearer risk management, and alignment with regulatory expectations, while allowing the Company to offer flexible solutions tailored to client needs. The benefits of these two packages are briefly summarized as follows:

First, maintaining the fund management package will allow the Company to generate stable and predictable fee-based income while assuming minimal insurance risk. This product is particularly attractive to corporate clients that prefer to self-fund their healthcare benefits and retain control over medical costs. From a risk management perspective, fund management arrangements reduce exposure to underwriting and claims volatility, support cash flow stability, and align well with prudent capital management, especially during periods of

market uncertainty. Continuing this product also enables the Company to leverage its core competencies in utilization management, provider network administration, and healthcare analytics without placing pressure on capital and reserve requirements.

Second, premium-based package will allow the Company to fulfill its role as a full-service HMO and addressing clients who require predictable healthcare costs and comprehensive risk coverage. This type of product meets the needs of small and medium-sized enterprises and individual members who may not have the financial capacity to self-fund medical expenses. While this packages carries with it underwriting and claims risks, they provide opportunities for scale and long-term client retention and higher revenue potential when managed prudently. Continuation of this product also supports market competitiveness and reinforces the Company's presence in the regulated HMO sector.

Third, offering both products enables diversification of revenue and risk. The fund management package provides lower-risk, service-oriented income stream, while the premium-based package offers growth potential and broader market reach. This balanced portfolio helps mitigate concentration of risk, smooth income volatility, and enhance financial resilience, which are key considerations under the Insurance Commissions' risk-based supervision.

Finally, the dual-product strategy aligns with regulatory expectations and consumer protection objectives. By clearly distinguishing between administrative-only arrangements and risk-bearing products, the Company can apply appropriate controls, pricing discipline, and disclosures for each offering. This clarity supports compliance with governance, solvency and market conduct requirements while allowing the Company to adapt its product mix in response to capital capacity, market demand and regulatory developments.

In summary, the continued offering of both fund management and premium-based package in the years ahead supports the Company's strategic flexibility, financial stability, risk management objectives and regulatory compliance, positioning the Company for sustainable growth in the evolving healthcare and HMO landscape.

INFORMATION TECHNOLOGY

The continuation of the Company's HMO business operation-particularly its focus on fund management packages and premium-based packages will be closely link to the development of an effective information technology (IT). Development of IT ahead will enhance the Company's ability to manage risk, control costs, improve service delivery and comply with regulatory requirements, making both product line s more viable and sustainable in the long term. The benefits of an effective IT is briefly described below.

For the fund management package, information technology will play a critical role in enabling accurate and transparent administration of client-owned healthcare funds. Robust IT systems will allow real-time tracking of fund utilization, automated claims processing, provider billing validation, and detailed reporting to corporate clients. These capabilities will strengthen client confidence, support data-driven decision-making, and enable proactive utilization management. As corporate clients increasingly demand timely analytics, cost transparency and customized reporting, continued investment in IT ensures that the Company can efficiently manage multiple client funds with minimal operational risk and administrative cost.

In the premium-based package, IT development will directly supports prudent underwriting and claims management. Advanced information systems will enable the collection and analysis of utilization data, claim trends and member demographics, which are essential for accurate pricing and benefit design. Automation and system integration will reduce processing errors, improve turnaround times and enhance fraud detection. These improvements will help control costs, protect margins and ensure that the Company can meet its obligations to members and providers in a timely manner.

Across both product types, IT development will strengthens enterprise risk management and regulatory compliance. Integrated systems will facilitate accurate financial reporting, monitoring of key risk indicators, and timely submission of regulatory reports to the Insurance Commission. Enhanced cyber security measures and data privacy controls will also protect sensitive member and provider information, supporting market conduct and consumer protection objectives.

Moreover, digital platforms will improve member and provider experience through online enrollment, electronic approvals, provider portals and customer support systems. These capabilities will increase operational efficiency, reduce manual intervention, and support scalability without proportionate increases in cost which is an important factor for sustaining both fund management and premium-based operations.

In summary, the continued operation of the Company's dual-product HMO model will be supported by advancements in information technology. Strategic investments in IT will enable efficient administration, stronger risk controls, improved transparency and regulatory compliance. IT development will also contribute to the long-term sustainability and competitiveness of both the fund management and premium-based HMO products.

ADOPTION OF PFRS 17

The adoption of Philippine Financial Reporting Standards 17 (PFRS 17) represent a shift in financial reporting for HMO companies effective

January 1, 2027 will reflect global developments in accounting and changing regulatory expectations. The shift in financial reporting policy for HMOs as required by the Insurance Commission is clarified under IC Circular 2025-25, which acknowledges the operational complexity of the standard and provides the industry sufficient transition time to build capabilities, systems and governance structures for compliance. Briefly summarized in the succeeding paragraph the principle-based framework of the standard.

> The new reporting standard will change how HMOs measure and recognize revenues, liabilities and profits. Instead of recognizing premium income largely on a cash or accrual basis, HMOs must measure insurance contract liabilities using future cash flows adjusted for time value of money and risk adjustments. Profits are no longer recognized upfront but are spread over the period during which the services are provided to members.
>
> The shift will practically impact the day-to-day operation of HMOs more specifically on the area of finance, actuarial, underwriting, medical management and information technology. HMOs need to upgrade or integrate systems to capture data at a level of granularity not previously required.
>
> HMOs are not traditional insurers but the contracts meet the definition of insurance contracts under PFRS 17, hence, the industry are included in the new standard to ensure that similar risk-bearing activities are accounted consistently across the insurance and health benefit sector.
>
> With the adoption of PFRS 17, the Insurance Commission will be able to monitor the solvency, sustainability and risk exposure in the HMO sector through constant valuation of liabilities, transparent recognition of profits and to monitor if the industry has sufficient financial capacity to meet obligations to members and providers.

In retrospect, adoption of PFRS 17 in the HMO industry is a broader move toward transparency, comparability and risk-based supervision. Although this may demand significant operational effort and investment, this will provide HMOs to modernize systems, improve financial discipline and align the business models with international best practices.

To this end in view, the Company is fully committed to embrace the implementation of the new standard and guaranties full compliance as required under the provision of IC Circular 2025-05.

CORPORATE SOLUTION

Corporate solutions for HMOs in the Philippines are largely shaped by regulatory framework and supervisory expectations of the Insurance Commission. These solutions are not merely operational enhancements but strategic and governance-driven responses to ensure regulatory compliance,

financial stability and sustainable delivery of health benefits to members. With the changing regulatory landscape of the HMO industry, regulatory requirements becomes more risk-based and aligned with international standard particularly with the impending implementation and full adoption of PFRS 17.

Among the corporate solutions applicable to HMOs are the following:

- The core of applicable corporate solutions is strengthened corporate governance thereby requiring HMOs to implement sound governance practices similarly imposed on insurance companies. HMOs are required to maintain a corporate governance manual requiring monitoring strict adherence on the policies stated thereto.

- Another critical corporate solution relates to capital management and net worth compliance. The IC imposes minimum net worth requirements to ensure financial stability of HMOs. Compliance thereto will ensure the meeting of financial obligations to members and healthcare providers. HMOs may also adopt holding company structures or shared service arrangements within a group to optimize capital efficiency while maintaining compliance with IC-prescribed solvency and net worth limits. This solutions support regulatory confidence thereby protecting policyholders and members.

- Enterprise Risk Management is also applicable to HMOs which will help to identify, assess, monitor and mitigate risks arising from underwriting, provider network management, pricing, operational processes and information technology. This will encompass the formal adoption of ERM framework aligned with IC risk-based supervision principles, integration of risk assessments into strategic planning and regular reporting to the Board and regulators.

- Information Technology and system enhancement is an essential corporate solution. Company needs to invest in integrated membership, claims, accounting and reporting systems in order to generate accurate and timely regulatory submissions to the Insurance Commission. In view of the changing regulatory landscape of the HMO industry, solutions become critical in ensuring consistency, reliability and regulatory acceptability of financial information.

- Professionalization of actuarial and financial management functions. IC expects actuarial involvement in pricing, reserving and sustainability assessment and this includes engaging licensed actuaries and aligning internal policies with IC-prescribed valuation and reporting standards.

- Product design and contractual restructuring is a corporate solutions adoptable to HMOs which help in reviewing, redesigning healthcare plans, provider contracts, membership agreement to ensure clarity of benefits, compliance with consumer protection rules in relation to regulatory definition of insurance and pre-need products.

- Regulatory engagement and compliance culture is also a vital corporate solutions applicable to HMOs to cope with regulatory functions to ensure timely communication with the Insurance Commission, prompt submission of reports and immediate response to regulatory findings and directives. This includes internal compliance monitoring, regular regulatory training for officers and staff.

In summary, corporate solutions for HMOs in the Philippines are linked to regulatory requirements of the Insurance Commission that aides to strengthened governance, capital management, enterprise risk management, systems enhancement, professionalized financial oversight, compliant product structures and compliance culture. These corporate solutions will enhance HMOs financial soundness and sustained healthcare delivery.

REGULATORY COMPLIANCE

Regulatory compliance for HMOs in the Philippines is a fundamental component of the authority to operate and guaranty credibility as providers of healthcare benefit arrangements. Selected regulatory compliance applicable to HMOs are described in the succeeding paragraph.

Compliance of HMOs begins with the licensing and authority to operate wherein the Company is required to secure and maintain a valid Certificate of Authority from the Insurance Commission. HMOs have to prove their capability to manage a healthcare risk and ability to deliver contracted services. IC strictly evaluates whether the conditions for the grant of authority remain satisfied.

Another aspect of regulatory compliance is financial soundness and net worth requirements. The IC prescribes the minimum net worth thresholds for HMOs to ensure the Company has sufficient financial resources to honor healthcare claims and provider obligations. HMOs are required to monitor capital adequacy and are promptly requires to address deficiencies through capital infusion.

Another pillar of regulatory compliance is financial reporting and regulatory submissions for which HMOs are under obligation to submit financial statements, quarterly reports and other prescribed schedules prescribed by the Insurance Commission. Accurate reporting allows the IC to conduct effective off-site monitoring and assess financial condition and risk profiles of each HMO.

Market conduct and consumer protection is another dimension of regulatory compliance and HMOs must ensure that the healthcare plans, membership contracts and marketing materials are clear, fair and not misleading. It also encompasses benefits, exclusions and limitations in the contracts. IC monitors compliance with consumer protection standards to safeguard the interest of members and to maintain public confidence in the HMO sector.

Regulatory compliance for HMOs in the Philippines is a comprehensive and continuous process that encompasses licensing, financial soundness, reporting, governance, risk management, market conduct, information systems and regulatory engagement. By adhering to this regulatory compliance, HMOs contribute to a stable and trustworthy healthcare benefits system while protecting the interests of their members and stakeholders.

MANAGING RISK

Managing risk Is a critical responsibility of HMOs in the Philippines and is closely aligned with the regulatory expectations of the Insurance Commission. While HMOs may not be a traditional life or non-life insurers, IC applies prudential and risk-based supervisory principles to ensure HMOs remain financially sound, operationally resilient and capable of delivering healthcare benefits to their members. Henceforth, effective risk management is both a regulatory requirement and core management function. Some of the types of risks that needs to be addressed by HMOs are briefly described below.

Risk management begins with the Board of Director and senior management who sets the risk appetite, risk policies and in charge of exercising oversight over material risk. Management are primarily responsible for the effective implementation of policies and ensures that risk considerations are integrated into strategic and operational decision making.

Underwriting and utilization risk arises from uncertainties of healthcare costs in relation to premiums and membership fees. To manage this risk, HMOs must exercise prudent pricing, benefit design and utilization controls like pre-authorization and network management.

Capital and solvency risk is also one of regulatory concern where IC requires HMOs to maintain minimum net worth levels to ensure the ability to meet obligations to members and healthcare providers. HMOs are expected to address potential capital shortfalls through capital infusions and/or adjustment in business strategy consistent with IC prudential standards.

Operational risk is risks arising from internal processes, human resources, information systems and external events. HMOs are expected to establish strong internal controls, segregation of duties, procedures and business continuity and disaster recovery plans. Thru

effective operational risk management, the likelihood of service disruptions, financial losses and regulatory breaches will be minimize.

Finally, risk reporting and regulatory engagement form an essential part of effective risk management. HMOs are expected to maintain clear documentation of risk assessments, controls and mitigation actions and to report material risks to the Board and possibly to Insurance Commission as well.

Managing risk for HMOs in the Philippines is a comprehensive enterprise-wide process that should align closely with the Insurance Commission's regulatory requirement. Through effective governance and compliance management, prudent financial controls and transparent regulatory engagement, HMOs will be able to manage risks responsibly and ensure sustainable delivery of healthcare services.

After a period of non-operation for the last two years, the Company's return to the Philippine healthcare market is anchored on a clear commitment to rebuild trust, restore operational capacity and align our business model with current regulatory and market realities.

The Company recognizes that re-entry into the market requires more than resumption of sales activities, it requires a comprehensive and integrated strategy that addresses marketing, technology, financial reporting, governance, regulatory compliance and risk management in a coordinated manner.

The Company commits to position itself for a stable and sustainable return to the Philippine HMO industry by adopting the policies described above for a sound market and business strategies in the coming year.

C. CORPORATE GOVERNANCE

As the Company prepares for full operational implementation in the coming year, it reaffirms its commitment to strong corporate governance and a clear corporate philosophy that supports sustainable growth, regulatory compliance and the protection of members' interests. The Board of Directors and Management recognize that sound governance is fundamental to restoring confidence, ensuring accountability and enabling the Company to operate in a prudent, ethical and transparent manner in accordance with the requirements and expectations of the Insurance.

The following section outlines the Company's governance framework through policy statement and corporate philosophy that define the values and principles guiding decision-making and oversight. It will also highlight the Company's focus on employee training and development as a critical enabler of competent operations, regulatory compliance and ethical conduct. Finally, it presents the Company's approach to customer operations, emphasizing service excellence, fairness and responsiveness to member needs as integral components of responsible corporate stewardship.

Through these governance initiatives, the Company aims to strengthen internal controls, enhance organizational capability and foster trust among regulators, stakeholders, employees and customers as it moves forward into its next phase of operation.

POLICY STATEMENT AND CORPORATE PHILOSOPHY

The Company fully adopts a corporate governance framework founded on accountability, transparency, fairness and responsibility. The Board of Directors assumes ultimate responsibility for the strategic direction of the Company, approval of key policies and the oversight of management performance. In the coming year, the Board commits to active supervision of the Company's financial condition, risk profile, and compliance of all applicable laws, regulations and IC circulars.

The Company shall maintain a clear separation between the rules of the Board and Management to ensure balanced decision-making and effective checks and controls. Board committees including Audit, Risk Management and Corporate Governance Compliance shall be strengthened or reconstituted to provide focused oversight on critical areas. Key control functions – internal audit, risk management and compliance shall operate with sufficient independence, authority and access to the Board.

In line with regulatory expectations, the Company commits to timely, accurate and transparent financial and regulatory reporting. Policies or conflicts of interest, ethical conduct and disclosure shall be enforced to ensure that decisions are made in the best interest of the Company, its members, providers and other stakeholders. The governance framework shall be reviewed regularly to ensure continuing relevance, effectiveness and alignment with evolving regulatory standards.

The Company's corporate philosophy is anchored on responsible healthcare stewardship, financial prudence and member-centric service. The Company recognizes its role as a trustee of members' healthcare contributions and commits to managing healthcare benefits in a manner that balances affordability, quality of care and long-term sustainability.

Integrity and compliance form the core of the Company's operating philosophy and all officers and employees are expected to uphold the highest standards of ethical behavior and to conduct business in full compliance with IC regulations, corporate policies and applicable laws. This philosophy supports resilience, protects capital, and ensures continuity of service to members, particularly as the Company re-establishes its market presence.

In summary, the Company's corporate governance policy statement and corporate philosophy will serves as a guiding principle for its operation the coming year. By upholding strong governance, ethical conduct, regulatory compliance and prudent risk management, the Company will aim to build a stable, credible and sustainable organization that will deliver reliable

healthcare benefits while meeting the expectations of regulators, members and other stakeholders.

EMPLOYEE TRAINING AND DEVELOPMENT

Employee training and development form a critical pillar of the Company's return to operation in the coming year and are integral to the effective implementation of its corporate governance principle. The Company believes that sound governance is not achieved solely through policies and oversight but also through a well-informed, competent and ethical grounded workforce that understands its roles and responsibilities, and accountability within the organization.

As part of its reactivation plan, the Company commits to establishing a structured governance-aligned training and development program designed to support transparency, accountability and regulatory compliance. All employees, from senior management to operational staff will undergo orientation and refresher training on the Company's corporate governance framework, code of conduct and ethical standards. Employees will also be trained on organizational structure, delegation of authority, and escalation protocols to enable them to understand how their key functions contribute to internal controls and regulatory compliance.

Leadership development will also be emphasized to ensure that supervisors and managers model good governance behaviors. Training for leaders will focus on ethical decision-making, effective supervision, performance management and communication.

Finally, employee training and development will be treated as an ongoing process, supported by regular assessments, feedback mechanisms and continuous improvement. Training outcomes will be aligned with performance evaluation and compliance monitoring, ensuring that governance principles are not only taught but practiced.

In summary, as the Company's returns to operation, employee training and development will be aligned with corporate governance principles to build competence, accountability, ethical conduct and risk awareness across organization.

CUSTOMER OPERATION

As the Company returns to full operation, customer operations are positioned as a key area where corporate governance principles are translated into concrete day-to-day practices.

Transparency and fairness will guide all customer-facing processes. The Company will ensure that members are provided with clear, accurate and timely information regarding plan benefits, coverage limits, exclusions, and procedures for availing services. Customer service personnel will be trained to

communicate benefits and decisions in a manner that is understandable and free from ambiguity, reinforcing trust and resolving risk disputes.

Customer operations will be supported by documented procedures and system-based workflows which will prevent errors, abuse and inconsistent treatment of members . Customer complaints and grievance handling will be handled not on a purely operational task. The Company will establish formal complaints management process with defined escalation, resolution timelines and reporting to senior management.

Data protection and confidentiality will also play an important part of good governance where strict controls will be implemented to safeguard members' personal and health information, consistent with data privacy laws.

Finally, the Company will view customer operations as a reflection of its corporate values and governance culture. Performance standards for customer service will be aligned with ethical conduct, compliance and quality of service rather than of volume or speed. Feedback mechanisms will be enforced to improve processes, demonstrating responsiveness and accountability.

In summary, as the Company returns to operation in the coming year, customer operations will be governed by strong corporate governance principles that emphasize transparency, fairness, and accountability and risk awareness. By embedding these principles into customer-facing processes, the Company aims to rebuild member trust, meet regulatory expectations and support sustainable and responsible growth.

PRESIDENT'S CLOSING STATEMENT

As we prepare to resume full operation in the coming year, I would like to reaffirm the Company's strong commitment to responsible, compliant and sustainable operation as a Health Maintenance Organization in the Philippines. Our return to the market will follow a period of careful assessment, restructuring and preparation to be undertaken with a clear understanding of our responsibilities to our members, healthcare providers, shareholders and regulators.

As we move forward, our focus will remain on delivering reliable, fair and sustainable benefits that will operate within a sound regulatory and ethical framework. We are committed to managing risks prudently, investing in capable people and systems and upholding the trust placed in us by our stakeholders.

With this renewed sense of purpose and responsibility, we look ahead to the coming year with confidence. Guided by strong governance, strict regulatory compliance and commitment to service excellence, we are prepared to responsibly return to operations and contribute positively to the Philippine healthcare system.

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