LOKOMO’S SICKNESS FUND RULES (from January 1, 2023 onward)

GENERAL PROVISIONS

SECTION 1
The insurance fund is called Lokomo’s Sickness Fund.
The Fund’s domicile is Tampere.

SECTION 2
The purpose of the Fund is to grant benefits in accordance with the Health Insurance Act and additional benefits based on these rules. The Fund serves as a workplace fund, as specified in the Health Insurance Act (1224/2004).

In addition to these rules, the Fund’s operations are governed by the Act on Company and Industry-wide Pension Funds (946/2021) and the Employee Benefit Funds Act (948/2021).

The general oversight of the Fund’s operations is carried out by the Financial Supervisory Authority. The Fund’s operations derived from the Health Insurance Act are supervised by Kela.

SECTION 3
The Fund must have a minimum of 300 insurees.

SPHERE OF OPERATION AND INSURANCE MEMBERSHIP

SECTION 4
The Fund’s sphere of operation covers all the individuals employed by the companies included in the list of shareholders. The list of shareholders also states any limitations regarding the companies’ inclusion in the sphere of operation. In these rules, a company is referred to as a shareholder. The list of shareholders is a public document, available on the Fund’s website.

The Fund’s sphere of operation covers the shareholders’ employees, and insurance memberships are mandatory. **An exception to this are those individuals who transferred to Metso Outotec Finland Oy from Outotec Finland Oy, Outotec Filters Oy and Metso Outotec Oyj in the merger on January 1, 2021 and had the opportunity to indicate within three months (January 1–March 31, 2021) that they did not wish to join Lokomo’s Sickness Fund by virtue of the merger. As of April 1, 2021, the mandatory insurance will also apply to the aforementioned group of employees. Individuals who do not join at this time will not be able to join the Fund at a later stage.**

Additionally, the Fund’s sphere of operation includes the following groups, provided that the conditions below are met:

Retired insurees: An individual who retires from a shareholder’s service may continue their insurance membership. This requires that the individual has been insured by Lokomo’s Sickness Fund for no less than 15 years before retiring. Retaining an insurance membership is voluntary, and a notification regarding the matter must be submitted within three months of being granted a pension.

Other insurees: The Fund’s sphere of operation may also include individuals who, without having retired, have had to resign from the service of a shareholder or the Sickness Fund, who were insured by Lokomo’s Sickness Fund for no less than 15 years before their resignation and who are not in employment or working as entrepreneurs. Other insurees have a right to carry out temporary work during their insurance term, and may remain employed or work as entrepreneurs continuously for up to four months. Retaining an insurance membership is voluntary, and a notification regarding the matter must be submitted within three months of the termination of an employment contract. Other insurees become retired insurees once they have been granted a pension. A notification of this change must be submitted within three months of when pension was granted.

Retired and other insurees only have a right to receive additional benefits, specified in these rules.

Limitations on belonging to the sphere of operation:
The Fund's sphere of operation does not include individuals whose employment is intended to be short-term in nature, lasting up to four months, or who work less than 50% of the regular working hours.

A part-time pensioner/part-time disability pensioner whose working hours are less than 50% of the regular working hours may be a member of the Fund as a retired insuree.

The sphere of operation does not include individuals insured by another sickness or insurance fund.

The duties of the Fund's board include concluding that the grounds for being insured exist.

Upon becoming an insuree of the Fund, the individual is sent information about the Fund's rules and procedures via email or by post. Insurees will be notified of the provisions and any amendments to the rules on the Fund's website.

RESIGNATION AND EXPULSION FROM THE FUND

SECTION 5
An insuree will cease to be a member of the Fund when they are no longer part of its sphere of operation.

An insuree cannot be expelled from the Fund.

A retired insuree can resign from the Fund by sending a written notice to the Fund. A retired insuree will be considered as having resigned from the Fund if they have not made insurance contributions for a period of three months. A resignation from the Fund is considered to have taken place at the end of the month in which notice was given or a payment default was identified.

If a retired insuree is placed in permanent institutional care, their insurance membership is terminated.

A retired person who resigned from the Fund while retired does not have a right to rejoin the Fund.

Other insurees can resign from the Fund by submitting a written notification to the Fund board, or by becoming employed or entrepreneurs. Other insurees will be considered as having resigned from the Fund if they have not made insurance contributions for a period of three months. A resignation from the Fund is considered to have taken place at the end of the month in which notice was given or a payment default was identified.

If other insurees are placed in permanent institutional care, their insurance membership is terminated.

Other insurees who have resigned from the Fund do not have a right to rejoin the Fund.

SECTION 6
A shareholder may resign from the Fund by submitting a written resignation notice to the Fund no less than six months before the resignation date.

A shareholder cannot be expelled from the Fund.

SECTION 7
An insuree or a shareholder that resigns from the Fund will have no claim to the Fund's assets.

INSURANCE CONTRIBUTIONS

SECTION 8
The Fund's insurance premium is 1.1 per cent of the salary that a shareholder pays to the employee based on the Tax Prepayment Act (1118/1996). The Fund's monthly insurance contribution cap is calculated by using the following formula: The average hourly pay calculated from the insurance contributions charged to the insurees x 2.7. The board may lower the insurance contribution cap in its annual plan, if the Fund's financial situation allows.

The insurance contribution for retired insurees is 1.7 per cent of their pension income. The insurance contribution cap is the same as in Subsection 1.

Other insurees' insurance contributions are fixed and decided annually at the November fund meeting.

If a shareholder notifies the Fund that an insuree will be transfered to work abroad, the insurance membership will be suspended and the individual will not be eligible for the benefits defined in Sections 14–16 of these rules.

Each shareholder pays a quarterly insurance contribution on behalf of their employed insurees, amounting to half of the costs covered by the Fund as an additional benefit for physiotherapy, physiotherapeutic examinations and massage, according to Section 14, Subsection 1, Paragraphs 2c, 4c and 9.

Each shareholder must also make an annual shareholder's insurance contribution based on the number of insurees they employ. The amount per insuree is set at the fund meeting in November. A shareholder's contribution is calculated based on the number of insurees in the month preceding the November fund meeting. A shareholder that promotes the Sickness Fund's operations to an equal extent by some other means may be exempt from the contributions by the board's decision.

SECTION 9
A shareholder must withhold the insurance contributions from an insuree's pay when paying out salaries. The insurance contributions must be transferred to the Fund no less than once a month.

A retired insuree must provide the Fund with all the information necessary for determining their insurance contribution amount when submitting an application and make their contributions as specified by the board. Other insurees must make fixed insurance contributions monthly to the Sickness Fund's account.

SECTION 10
If the Fund's financial situation allows, the Fund's board may reduce or increase the contributions and minimum or maximum amounts specified in Section 8 by up to 40 per cent. Any changes to the contributions must be approved by the shareholder before their implementation. However, a change exceeding six months in duration must be made through a rules amendment.

OPERATIONS GOVERNED BY THE HEALTH INSURANCE ACT

SECTION 11
An insuree has a right to the following, as laid out in the Health Insurance Act and the provisions pursuant to the Act:

1) compensation for necessary medical care costs due to an illness;

2) daily allowance due to disability caused by illness;

3) compensation for the necessary costs due to pregnancy and childbirth;

4) pregnancy, special pregnancy and parental allowance;

5) daily allowance as intended in Section 18 of the Act on the Medical Use of Human Organs, Tissues and Cells (101/2001).

SECTION 12
The benefits, paid according to the Health Insurance Act, their amounts and restrictions, the start and end dates of an insurance membership, the benefit applications and payments, appeals and the duties connected to the operations governed by the Health Insurance Act are determined by the Act, and the provisions and regulations pursuant to the Act.

SECTION 13
The Fund has a right to receive the necessary funds from Kela's National Health Insurance Fund to pay out benefits in accordance with the Health Insurance Act, as well as reimbursement of the Fund's administrative costs, as laid out in the Health Insurance Act and the Government Decree on the Implementation of the Sickness Insurance Act (1335/2004).

ADDITIONAL BENEFITS

SECTION 14
The fund compensates its insured members for necessary treatment by a doctor or other appropriate professional due to sickness, pregnancy or childbirth. This compensation covers the actual cost of treatment, but – without jeopardizing the health of the insured individual in question – excludes any unnecessary costs. In the context of these rules, dentists are also regarded as doctors. An amount specified in Section 17 is deducted from the reimbursement sum before it is paid out.

Employed insurees' compensation includes the following:
1a) 80 per cent of doctor's and dentist's fees, if treatment is necessary and provided to manage a condition other than a dental condition. Includes endoscopy through natural orifices (esophagoscopy, gastroscopy, duodenoscopy, colonoscopy and sigmoidoscopy), included in the medical bill;
b) 80 per cent of administration fees charged together with the doctor's fee;
c) Public-sector client fees according to the maximum amounts specified in the Decree on Client Fees in Social Welfare and Health Care (912/1992), apart from dental care fees:

- outpatient clinic fees
- health center fees
- serial treatment fees
- ambulatory surgery treatment fees
- day ward fees
- hospital-at-home and homecare fees; available for up to four months per calendar year;

d) 80 per cent of psychologist's and psychotherapist's fees, if treatment is prescribed by an occupational health physician;
the duties of the Fund's board include providing further guidelines on item d.

2a) A hospital's or health center's daily fees and the basic rate up to the lowest payment category amount of a central hospital (excluding a psychiatric unit) for a maximum stay of 180 days due to the same illness; previous daily fees from the past two years are taken into account when calculating the maximum amount. If the insuree has been able to work for a period of 12 months, no previous daily fees are taken into account;
b) A rehabilitation institute's daily fees up to the amounts stated above in 2a, if deemed reasonable by the board in an individual case; and
c) A hospital's special-category fees and a private medical facility's fees reimbursed fully or partially, if deemed reasonable by the board in an individual case and if the treatment is not otherwise reimbursed based on Paragraphs 1–8.

3) Prescription medication, clinical food preparations and equivalent products, and emollients prescribed by a doctor are reimbursed, apart from the €5.00/drug excess, if compensation has also been received based on the Health Insurance Act.
The reimbursement amount is calculated from the price (reference price) that was used to calculate the compensation granted based on the Health Insurance Act. The initial deductible for medication, based on the Health Insurance Act, will not be reimbursed.

4a) 80 per cent of laboratory tests, pathology examinations and the related sample collection ordered by a doctor;
b) 80 per cent of radiology examinations ordered by a doctor, excluding other procedures carried out during examination, unless full or partial reimbursement is deemed reasonable by the board in an individual case;
c) 75 per cent of physiotherapy and physiotherapeutic examinations prescribed by a doctor, and up to eight (8) treatment sessions with one referral;
d) 75 per cent of podiatry prescribed by a doctor. Reimbursed podiatry must be provided by a podiatrist. Up to three (3) treatment sessions will be reimbursed with one referral.
The duties of the Fund's board include providing general guidelines on items c and d.

5a) Travel expenses, in accordance with the general guidelines issued by the Fund's board, that are necessary for receiving medical treatment or acquiring and maintaining assistive equipment or other equipment prescribed by a doctor. The cheapest mode of transport must be used, unless the nature of the illness or traffic conditions require the use of other means of transport;
b) Travel expenses of a doctor or other professional with appropriate qualifications, as intended in Section 15, Subsection 1, to visit a patient; and
c) Necessary accommodation expenses, according to the general guidelines issued by the Fund's board, if an insuree must, during their reimbursed trip, spend a night at an accommodation establishment or in accommodation arranged for patients by an examination or a treatment institution.

6a) Bandages, assistive equipment and prostheses prescribed by a doctor, if they cannot be acquired for free either permanently or temporarily. The acquisition cap is calculated by multiplying the average daily pay by two. The average daily pay is calculated from the insurance contributions charged to the Fund's insurees the previous year. Compensation may be paid out again after three years from the first reimbursement. The compensation amounts are calculated and confirmed annually by the Fund's board and entered into the Sickness Fund's annual plan;
b) Acquisition of equipment and measuring devices prescribed by a doctor, either fully or partially, if deemed reasonable by the board in an individual case.

7) Compensation is available for glasses, if prescribed by a doctor or an optician, according to the maximum amounts listed below. The lenses must be ground for the purpose of correcting a deficiency in eyesight. A sum equal to the eyeglass allowance is also available to be used for refractive eye surgery. The requirements for the compensation amounts and receiving compensation again are the same as for glasses.
a) Individuals who have been members of the Fund for at least a year will receive the maximum amount, calculated by multiplying the average daily pay derived from the insurees' previous year's insurance contributions by two. If an insuree has been a member for more than three years, compensation is paid according to item 7c. The compensation amounts are calculated and confirmed annually by the Fund's board and entered into the Sickness Fund's annual plan;
b) Compensation may be paid again with a multiplier of two, if a new pair of glasses is acquired after at least two years from the reimbursement of the previous pair have passed; or
c) at least three years have passed, in which case the multiplier is three.

8) Fee or payment other than what is stated under item 1 for treatment by a dentist, specialist dental technician or dental hygienist, including an oral examination, orthodontic treatment, prosthetic care and dental laboratory work, with the maximum additional compensation paid out annually as an additional benefit and calculated by taking the insurees' insurance contributions from the previous year to derive an average daily pay and multiplying it by two. The compensation amounts are

calculated and confirmed annually by the Fund's board and entered into the Sickness Fund's annual plan. Costs are reimbursed per calendar year, but not until an insuree has been a member of the Fund for at least a year.

9) Reimbursement of massage given by a licensed massage therapist or a massage school is granted based on
the annual plan's compensation cap, confirmed by the board. Massage allowance may also be used for treatment provided by a chiropractor, naprapath or osteopath.

When it comes to the benefits mentioned in items 1–8 above, the requirements are the same for **compensation paid to retired and other insurees** as for employed insurees, except that the maximum amounts are calculated based on the overall charges, including compensation received based on the Health Insurance Act and other legislation.
1) Up to 60 per cent of doctor's fees (items 1a and 1b), except
c) Public-sector client fees according to the maximum amounts specified in the Decree on Client Fees in Social Welfare and Health Care (912/1992), apart from dental care fees:

- outpatient clinic fees
- health center fees
- serial treatment fees
- ambulatory surgery treatment fees
- day ward fees
- hospital-at-home and homecare fees; available for up to four months per calendar year;

d) 60 per cent of psychologist's and psychotherapist's fees, if treatment is prescribed by a doctor.
2) 75 per cent of laboratory tests, pathology examinations and the related sample collection ordered by a doctor.
3) 75 per cent of radiology examinations ordered by a doctor, excluding other procedures carried out during the examination.
4) 33 per cent of a massage without a referral; a series of up to five sessions a year.
5) 50 per cent of physiotherapy and physiotherapeutic examinations prescribed by a doctor; up to eight treatment sessions with one referral.
The duties of the Fund's board include providing general guidelines on massages and physiotherapy.
6) For dental care up to the annual maximum amount, calculated based on the average daily pay derived from the insurance contributions of the Fund's insurees for the previous year, multiplied by 1.5.
7) Retired and other insurees are reimbursed for hospital care for up to 180 days for the entire time that they have been members outside of their employment time.

SECTION 15
According to these rules, a reimbursable examination or treatment must be provided by a person with appropriate professional qualifications who must be included in the National Supervisory Authority for Welfare and Health, Valvira's, central registry of professionals, or examinations/treatment must be carried out at a private health care unit as specified in the Private Health Care Act (152/1990).

Necessary treatment and examinations are defined as generally approved medical care that complies with good treatment practices. Doctor's orders must be secured before undergoing reimbursable events. This document entitles to compensation for one year from the document's issuing date. Medication, clinical food preparations and emollients may be reimbursed for a period that equals a course of treatment of up to three months in duration.

Treatment provided abroad is reimbursed up to the amount that the treatment would have cost had it been provided in Finland. Travel expenses to and from abroad are not reimbursed.

SECTION 16
In the event of an insuree's death, a funeral allowance is paid out. The amount is calculated by taking the insurees' insurance contributions from the previous year to derive an average daily pay and multiplying it by twenty. The amount of the allowance is calculated and confirmed annually by the

Fund's board and entered into the Sickness Fund's annual plan.

The funeral allowance is paid out to a spouse or cohabiting partner, if the insuree was married or in a cohabitation relationship. Otherwise, the payment is made to the insuree's children or, if none exist, to the insuree's parents or, if neither is still alive, to the estate of the deceased. If it is reasonable to assume that an individual entitled to the allowance will not arrange for the funeral, the board may decree that actual funeral expenses will first be paid out from the allowance to the person that has made the funeral arrangements.

No funeral allowance is paid out in the event of a retired or other insuree's death.

SECTION 17
The Fund will only pay out benefits defined in Sections 14–15 if and to the extent that they exceed similar compensation received based on the Health Insurance Act. If an insuree is entitled to compensation based on other Finnish legislation in addition to the Health Insurance Act, they must only be compensated for the amount that exceeds the compensation received based on the other laws. Similarly, if an insuree has a right to receive compensation based on the legislation of another country, the board may decide to take this compensation into account, either fully or partially, when determining the compensation amount.

SECTION 18
The Fund becomes responsible for additional benefits at the start of an insurance membership and ceases to be responsible at the end of it. The Fund will only reimburse costs incurred during the membership. Compensation for medical care will only end when the maximum period defined in Section 14, Subsection 2, Paragraph 2a ends, if the medical care began during the insurance membership or if the insuree retires before that and begins receiving old-age pension.

RESTRICTIONS REGARDING ADDITIONAL BENEFITS

SECTION 19
If an insuree falls ill while not working because of a work stoppage or furlough due to a shortage of work and is not receiving pay for this period, they will not receive additional benefits, as defined in Sections 14–15 of these rules, for the period in question.

Regardless of when the illness began, the benefits defined above will not be paid out for the duration of the payment suspension, specified in Section 8, Subsection 4.

However, as an exception, additional benefits are granted to insurees who have a right to receive a daily allowance, loss-of-income compensation or care allowance due to illness, injury or family leave, according to the Health Insurance Act or other legislation.

In situations described above in Subsection 1, compensation according to Sections 14–15 may be paid out and insurance contributions may be collected if the board so decides.

SECTION 20
If an insuree has fraudulently provided the Fund with incorrect or insufficient information after an insured event, pertinent to the receipt or size of an additional benefit, the benefit they are entitled to may be denied or reduced according to what is reasonable, considering the circumstances.

The Fund may withhold an outstanding amount that an insuree has been billed for from a benefit to be paid out to them.

SECTION 21
In terms of the additional benefits, the Fund may not be held responsible if an insuree has deliberately

caused an insured event to occur.

If an insuree has caused an insured event due to gross neglect, they may be denied a benefit that they would otherwise be entitled to, the benefit amount may be reduced or a benefit already granted may be suspended according to what is reasonable, considering the circumstances.

Subsection 2 also applies to instances in which an insuree has deliberately hindered their convalescence or has not agreed to an examination or treatment prescribed by a doctor appointed by the Fund, without an acceptable reason, apart from procedures that pose serious danger to health.

SECTION 22
The Fund's board has a right to determine which service provider must be used when it comes to treatment compensated for as an additional benefit according to these rules.

In order for a compensation claim to be processed, an insuree is obliged to attend examinations at the board's expense, with the service provider assigned by the board and when instructed to do so by the board.

If the insuree does not comply with the order issued by the Fund's board, based on Subsection 1 or 2, the compensation may be denied either fully or partially.

ADDITIONAL BENEFIT APPLICATIONS AND PAYMENT

SECTION 23
Applications for additional benefits described in these rules must be made in writing. An adequate description must be attached to the application.

Compensation must be applied for within six months of the date that the payment for which compensation is applied for was made. Funeral allowance must be applied for within six months of when a right to receive it was gained. However, despite a late application, an allowance may be granted either fully or partially if denying it is considered unreasonable.

Benefit applications must be processed with urgency. Benefit delays are governed by Chapter 6, Section 8 of the Employee Benefit Funds Act.

SECTION 24
Compensation according to Sections 14–15 of these rules may be paid out in full, without Section 17 preventing this, if the receipt of other compensation specified in the latter Section is delayed due to reasons beyond the insuree's control or if the insuree agrees to pay the Fund back a portion of the compensation they have received based on the Health Insurance Act or other legislation that equals the compensation paid out by the Fund.

SECTION 25
If an insuree or other beneficiary has received an additional benefit exceeding the amount that they were entitled to, according to these rules, the erroneously paid benefit must be recovered.

An erroneously paid additional benefit may be left unrecovered, either fully or partially, if that is deemed to be reasonable and the benefit is not deemed to have been paid out due to fraudulent actions of the insuree or beneficiary or their representative, or if the amount to be recovered is small.

An erroneously paid out additional benefit may also be recovered by deducting it from future additional benefits.

APPEALING ADDITIONAL BENEFIT DECISIONS

SECTION 26

A person dissatisfied with the Fund's additional benefit decision may request a recommendation for a resolution from the Finnish Financial Ombudsman Bureau. An insuree must submit the request to their own Fund or the Finnish Financial Ombudsman Bureau within 30 days of when they received information of the decision. An insuree will be considered to have received information about the decision on the seventh day from when the decision was sent.

A person dissatisfied with an additional benefit decision may also submit the matter to a court. A claim must be lodged within three years of the date that the person dissatisfied with the benefit decision received information about the Fund's decision and about the three-year deadline. Pirkanmaa District Court, which is the general lower court in the Fund's domicile, will serve as the court. A claim may also be reviewed by the district court of the region where the claimant has their domicile or permanent residency.

EQUITY FUND

SECTION 27

The Fund has a reserve fund and an operating fund.

The reserve fund must be increased annually by no less than 20 per cent of the surplus, indicated in the financial statements, after the deficit from previous financial years, indicated in the balance sheet, has been deducted from it. Once the reserve fund is at least as large as the average of the current financial year and two previous financial years, transfers to the reserve fund are no longer mandatory.

The reserve fund may be diminished, based on a fund meeting decision, only to cover a deficit indicated in a confirmed balance sheet.

Without being prevented from doing so by Subsection 3, the Financial Supervisory Authority may grant the Fund permission, based on an application and special grounds, to reduce its reserve fund amount, but usually this amount may not be lower than a full reserve fund.

SECTION 28

The portion of the surplus that has not been transferred to the reserve fund must be transferred to the operating fund.

The operating fund may be used for the following purposes:

1) primarily to cover a deficit indicated in the financial statements;
2) at the board's discretion, to increase benefits governed by Sections 14–16 and/or as compensation for the cost of rehabilitation provided to prevent an illness or inability to work or improve the ability to work and earn an income, in accordance with the plan confirmed by the board for up to a year at a time; and
3) for a purpose mentioned in Section 19, Subsection 1.

TECHNICAL PROVISIONS

SECTION 29

The Fund's technical provisions are formed by an outstanding claims reserve, which equals the outstanding amounts of compensation and other amounts to be paid due to insured events that have occurred. The outstanding claims reserve is calculated for the financial statements by following principles that comply with the Financial Supervisory Authority's regulations.

FINANCIAL STATEMENTS

SECTION 30
The Fund's financial year is one calendar year.

Financial statements must be compiled for each financial year, in accordance with the Ministry of Social Affairs and Health decree No 1196/2021 and the Financial Supervisory Authority's regulations, and must include a profit and loss account and a balance sheet with its attachments. The financial statements must also include an annual report. The financial statements and annual report must be submitted to the auditors for auditing no less than a month before an ordinary fund meeting.

SECTION 31
If the operating fund is insufficient to cover a deficit, the reserve fund must be used.

The Fund is not obligated to make additional payments, as described in Chapter 4, Section 12 of the Employee Benefit Funds Act.

AUDIT

SECTION 32
The Fund must have one auditor appointed for one calendar year at a time.

A natural person or an approved audit firm may be chosen as the auditor.

If a natural person is chosen as the auditor, a deputy auditor must also be nominated.
A deputy auditor will not be chosen for an audit firm.

The auditor and their deputy auditor must be auditors in accordance with the Auditing Act (1141/2015).

SECTION 33
Auditors must audit the Fund's financial statements, books and administration to the extent required by the customary standards of their profession and provide the board with an audit report for each financial year.

FUND MEETING

SECTION 34
The highest decision-making power is held by the fund meeting, which any insuree and shareholder of the Fund may attend and speak at.

A fund meeting must be held in the Fund's domicile. If the board so decides, a meeting may also be attended by post, via telecommunications means or with the help of some other technical aid.

SECTION 35
Every insuree has one vote at a fund meeting. An insuree may exercise this right at a fund meeting either in person or through an agent. An agent may represent up to two insurees.

At a fund meeting, the shareholders represent a number of votes that equals to 35 per cent of the total number of votes of the insurees represented at the meeting. The number of votes is divided between the shareholders according to the number of insurees.

An insuree's agent and a person who exercises a shareholder's right to vote must present a dated and detailed authorization document.

SECTION 36
The Fund holds two ordinary fund meetings a year; one is held in April at the latest and the other no later than in November.

The ordinary fund meeting held no later than in April:

1) presents the financial statements and audit report;
2) decides on the confirmation of the previous year's financial statements;
3) decides on granting discharge to the board members and the CEO;
4) decides on using a surplus or covering a deficit;
5) decides on other measures that the previous year's operations and financial statement may have prompted; and
6) discusses any other items mentioned in the meeting invitation.

The ordinary fund meeting held no later than in November:

1) sets the fees paid to the board chair. other board members and the auditors;
2) appoints the necessary members and deputy members to replace board members and deputy members whose turn it is to step down;
3) appoints an auditor and, if necessary, a deputy auditor; and
4) discusses any other items mentioned in the meeting invitation.

SECTION 37
An extraordinary fund meeting must be held if the board deems it necessary.

Similarly, an extraordinary fund meeting must be held if so demanded, in writing, by fund meeting attendees who have voting rights and constitute at least a tenth of the total number of attendees who hold voting rights, by the Financial Supervisory Authority or by the Fund's auditor in order to discuss a specific matter.

SECTION 38
An invitation to a fund meeting must be sent no earlier than four weeks and no later than a week before a meeting. If a decision on a matter discussed at a fund meeting is postponed to a follow-up meeting, a separate invitation must be sent if the meeting is to be held later than within four weeks.

A meeting invitation to an extraordinary fund meeting must be sent within two weeks of a demand made according to Section 37, Subsection 2 of these rules.

A meeting invitation and other Fund notifications are communicated on the Sickness Fund's website and employers' intranets, where possible. Meeting invitations are sent to the shareholders separately by post or via email.

SECTION 39
An invitation to a fund meeting must include the meeting time and place, as well as the items to be discussed at the meeting. If a fund meeting is to discuss the financial statements, the documents, or copies thereof, that pertain to the financial statements must be available at the Fund's office for at least a week before the meeting to allow those with a right to vote at a fund meeting to view them. The same applies if a fund meeting is to discuss an amendment to the rules. A meeting invitation must state that the documents may be viewed prior to the meeting.

If a fund meeting is to discuss amendments to the Fund rules, the main content of the amendments must be stated in the meeting invitation.

SECTION 40
At a fund meeting, the discussions are led by a person appointed for this duty by the meeting.

Unless otherwise decreed by legislation or these rules, a fund meeting decision shall be the opinion that receives more than half of the votes cast or, if the votes are evenly split, the one supported by the chair. Whoever receives the most votes shall be the winner of an election. If votes are evenly split, the result shall be drawn by lot.

A decision that concerns an amendment to the Fund rules will only be valid if at least two thirds of the meeting attendees with a right to vote support it.

If a rule amendment concerns a shareholder's rights or obligations directly, the confirmation of the amendment will also require that the shareholder consents to the amendment, either at a fund meeting or otherwise. If multiple shareholders are affected, the confirmation of the amendment will require that at least two thirds of all the shareholders have approved the amendment, either at a fund meeting or otherwise. Furthermore, the number of votes cast by shareholders in support of the amendment must be no less than two thirds of the total number of votes that the shareholders would have had if all the shareholders had been represented at the fund meeting (Chapter 2, Section 15, Subsection 2 of the Act on Company and Industry-wide Pension Funds, 946/2021).

SECTION 41
A decision on a matter the processing of which has not complied with this legislation regarding procedures or the provisions laid out in these rules on meeting invitations may only be made with the consent of the insurees and shareholders affected by the nonconformity. If, according to legislation or these rules, the matter must be processed at a fund meeting, the fund meeting may decide on it even if the matter was not mentioned in the meeting invitation. Furthermore, the fund meeting may always decide to convene for an extraordinary fund meeting to discuss a specific matter.

Insurees and shareholders have a right to include a matter on the fund meeting agenda to be discussed, if they make a written request to the board well in advance so that the matter can be included in the meeting invitation.

SECTION 42
Minutes shall be kept of the fund meetings, listing all the attendees entitled to vote, and stating their number of votes, the decisions made at the meeting, the time and date of a voting, and the voting result. The minutes must be reviewed and signed by the chair and at least two attendees entitled to vote, appointed specifically for this purpose at the meeting. The minutes must be numbered in a sequential order and stored in a reliable manner. Minutes must be stored in the Fund's office or otherwise displayed to the insurees and shareholder(s) no less than two weeks from a meeting.

BOARD

SECTION 43
The Fund's board has nine actual members, each of whom must have a personal deputy member.

The board is appointed by the fund meeting. The insurees choose eight board members and their deputies. The shareholder chooses one board member and their deputy. Persons who are 68 or older may not be nominated for the board.

The board members' term of office is two calendar years in duration. Each year, four members and their deputies chosen by the Fund members, as well as one member and their deputy chosen by the shareholder, must step down from the board.

The board chair and vice-chair are paid a monthly fee, the amount of which is determined by the fund meeting. The amount of the board members' meeting attendance fees is determined by the fund meeting.

SECTION 44
The board represents the Fund, and manages the Fund's administration and appropriate functioning.

In particular, the board's duties include the following:

1) selecting and dismissing a CEO and Fund officials, and determining the terms regarding their office;
2) providing the CEO with the instructions and guidelines necessary to carry out the Fund's day-to-day management and overseeing other operations;
3) making appropriate arrangements for the Fund's bookkeeping and financial management;
4) making decisions on investing the Fund's assets and taking out loans;
5) making decision on granting benefits, unless the board has given these decision-making rights to the CEO or a fund official;
6) convening fund meetings, preparing the items to be discussed at a meeting and making a proposal in the annual report to the meeting regarding the measures pertaining to a surplus or deficit indicated in the financial statements;
7) granting authorizations to sign documents on behalf of the Fund.

SECTION 45
The board selects a chair and a vice-chair from among its members annually. The CEO may not serve as the board chair.

The board convenes at the invitation of the chair or, if the chair is indisposed, the vice-chair's invitation. The board must be convened by the chair if a board member or the CEO so demands.

A quorum is met when the chair or the vice-chair and at least four other board members are present.

The board's decision shall be the proposal that more than half of the attendees support or, if the votes are evenly split, the one that is supported by the chair.

A board member or the CEO may not attend a discussion on a matter that affects the relationship between them and the Fund or their personal interests in any other way.

SECTION 46
Minutes must be kept of the board meetings and signed by the meeting chair and the author of the minutes. Minutes must be reviewed by at least one member appointed specifically for each meeting by the board. A board member and the CEO have a right to have their differing opinion on a matter be entered into the minutes. The minutes must be numbered in a sequential order and stored in a reliable manner.

Minutes must state:
1) a meeting's date, start and end times, and location;
2) the board members and other individuals present at the meeting;
3) the items discussed at the meeting, the decisions made, voting carried out and differing opinions; and
4) conflicts of interest and other matters deemed to be relevant.

CHIEF EXECUTIVE OFFICER

SECTION 47
The CEO's duty is to carry out the Fund's day-to-day management according to the instructions and guidelines provided by the board. The CEO must ensure that the Fund's books comply with legislation and that its financial management has been appropriately arranged.

The CEO has a right to represent the Fund in matters that are within the scope of their duties, according to Chapter 4, Section 13 of the Act on Company and Industry-wide Pension Funds.

SIGNATURES ON BEHALF OF THE FUND

SECTION 48
The Fund's name may be signed by the board chair, vice-chair or the CEO; the name must always be signed together by two of the aforementioned parties or by one together with a board member.

INVESTING FUNDS AND TAKING OUT LOANS

SECTION 49
The Fund must invest its assets in a manner that provides security and profit, and ensure the Fund's ability to make payments.

The Fund's assets may not be used for purposes outside of the Fund's scope.

The Fund must adapt its operations to be viable without borrowing. However, the Fund may take out temporary short-term loans to maintain its liquidity. The Fund may not give guarantees.

ALTERING SHAREHOLDER'S OBLIGATIONS

SECTION 50
If a shareholder wants to change the insurance contributions stated in Section 8, Subsection 5 or cancel other obligations included in these rules that concern the shareholder, they must notify the Fund in writing no less than six months before the implementation of the change.

If a shareholder's consent concerning mandatory insurance is cancelled, it will remain in force for six months after the Fund has received the notification of the cancellation.

After receiving a notification as specified in Subsections 1–2, the Fund must take action without delay to carry out the necessary changes to the rules. The same applies if a shareholder has given notice of their resignation, as specified in Section 6, Subsection 1.

MERGER AND DIVISION

SECTION 51
The Fund may not merge or divide as decreed in Chapter 7 of the Employee Benefit Funds Act.

TRANSFER OF THE INSURANCE PORTFOLIO, VOLUNTARY LIQUIDATION AND DISMANTLING THE FUND

SECTION 52
Chapter 8 of the Employee Benefit Funds Act must be complied with when transferring the Fund's insurance portfolio, undergoing voluntary liquidation or dismantling the Fund and carrying out the measures required.

STATUTORY LIQUIDATION AND DISMANTLING

SECTION 53
Chapter 9 of the Employee Benefit Funds Act must be complied with when undergoing voluntary liquidation or dismantling the Fund and carrying out the measures required.

The Fund must be liquidated and dismantled:
1) if the number of insurees at the end of the previous two calendar years has not met the minimum number specified in Section 3, and it cannot be deemed likely that the number will increase within the next four months to the specified higher number;

2) if the Fund's financial statements indicate a deficit and the deficit is not covered within the next two financial years; and
3) if the Fund does not comply with the principles of calculating the technical provisions or the requirements for covering the technical provisions and differentiating the cover;
4) if all its shareholders terminate the operations in which the insurees work;
5) if specifically decreed so by the rules;
6) if the Financial Supervisory Authority has ordered the Fund to be dismantled.

SECTION 54

If the Fund is dismantled, the remaining assets will be divided between those who were insured by the Fund when the liquidation procedure began. The assets will be divided in proportion to the insurance contributions they have made within the 36 months that immediately preceded the liquidation. If the amount of assets to be divided is small, the fund meeting may, with a majority of two thirds of the votes, decide that the assets be used for some other activity comparable to the Fund's operations or a non-profit purpose.

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Approved by the fund meeting on November 22, 2022
Confirmed by the Financial Supervisory Authority on November 23, 2022