Valid as of 1 August 2023

Approved by the General Fund Meeting on 27 April 2023

Confirmed by the Financial Supervisory Authority on 6 June 2023

# RULES OF SAIRAUSKASSA SILTA SICKNESS FUND

## GENERAL PROVISIONS

**Section 1**

The name of the insurance fund is Sairauskassa Silta (Silta Sickness Fund). The fund is domiciled in Järvenpää.

**Section 2**

The fund's purpose is to grant benefits in accordance with the Finnish Health Insurance Act and additional benefits as specified in these rules. The fund acts as an employer's fund as referred to in the Finnish Health Insurance Act (1224/2004).

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

The overall supervision of the fund's operations lies with the Finnish Financial Supervisory Authority.

The fund's operations according to the Health Insurance Act are supervised by the Social Insurance Institution of Finland (Kela).

**Section 3**

The fund shall have at least 300 insured.

## SPHERE OF OPERATIONS AND INSURANCE RELATIONSHIP

**Section 4**

The fund's sphere of operations comprises the persons employed by the following employers:

1. Valmet Technologies Oy;
2. Valmet Oyj;
3. Valmet Automation Oy;
4. Valmet Flow Control Oy;
5. The persons employed by the company named Vindea Oy who were insured in this fund on 31 December 2020;
6. The persons employed by the company named Transval Management Oy who were insured in this fund on 30 March 2017;

7. Sairauskassa Silta;
8. Stairon Oy;
9. Sahlsten Pakkaus Oy;
10. AirCom Oy;
11. Niini & Co Oy, Turku region;
12. ISS Palvelut Oy;
13. FSP Finnish Steel Painting Oy;
14. Jarparo Oy;
15. Jarparo Works Oy;
16. The persons employed by the company named Suunnittelutoimisto Hotanen Oy who were insured in this fund on 31 December 2020;
17. Metso Oyj.

A person included in the fund's sphere of operations has the right to join the fund as an insured person. Being included in the sphere of operations requires that the person receives their main income from the employer.

A person must be insured in the fund at the latest within 3 months of entering into the employ of an employer. The insurance relationship begins, if the conditions are met, at the start of the month following the application.

A person who is insured in another sickness or insurance fund cannot belong to the sphere operations.

When applying these rules, a person transferring from a company that belongs to the same group as an employer included in the sickness fund's sphere of operations can have their previous insurance relationship in a sickness fund within the sphere of the company in question credited to them.

Insured pensioner:
In addition, the fund's sphere of operations includes persons retiring directly from the employ of employers and the sickness fund who have been insured in Sairauskassa Silta for a minimum of 10 years before retiring.

The insurance relationship of a retired person is voluntary, and if the person wishes to continue their insurance relationship, they must inform the fund thereof in writing within three months of having received notice of the pension decision.
Retired insured persons are only entitled to the additional benefits specified in these rules.

Other Insured:

The fund's sphere of operations also includes persons who, without retiring, after having reached the age of 59 years, have been laid off for financial or production reasons from the employer's service and who have been insured in the fund for at least 10 years before being laid off, and who are neither employed nor self-employed.

For Other Insured, the insurance relationship is voluntary, and if such a person wishes to remain insured, they must inform the fund thereof in writing within three months of the termination of their employment.

Other Insured are only entitled to the additional benefits specified in these rules.

After the insurance relationship of Other Insured, upon having received a pension decision, such a person cannot become an insured pensioner, but instead can choose to remain an Other Insured person.

It is the fund's Board of Directors' duty to determine whether the conditions for an insurance relationship are valid.

The Board of Directors can, by issuing a separate decision for a fixed period of time, enable also persons employed by an employer who have not previously joined the fund as insured persons to apply for an insurance relationship.

When the insurance relationship begins, the insured are sent the rules of the fund by email or by post. The insured are informed of the rules and rule amendments on the insurance fund's website.

## RESIGNING AND DISMISSAL FROM THE FUND

**Section 5**

An insured person resigns from the fund when they no longer belong to its sphere of operations or after having submitted written notice of their resignation to the fund. The resignation is considered to have taken place at the end of the month in which notice was given.

A person who has resigned from the fund without their employment having ended is not entitled to rejoin the fund as an insured person.

An insured person cannot be dismissed from the fund.

A retired person insured in the fund resigns from the fund after having submitted written notice of their resignation to the fund. A retired insured person is considered to have resigned from the fund if they have neglected to pay the insurance contributions for three (3) months. The resignation is considered to have taken place at the end of the month in which notice was given or during which the non-payment was detected. If a retired insured person is admitted to permanent institutional care, their insurance relationship is considered to have ended.

A retired person who has resigned from the fund while on pension does not have the right to rejoin the fund as an insured person.

An Other Insured person resigns from the fund insurance relationship after having submitted written notice of their resignation to the fund's Board of Directors, or after becoming employed or self-employed. Employment or self-employment during the insurance relationship can last no longer than three (3) months without the insurance relationship ending. An Other Insured person is considered to have resigned if they have neglected to pay the insurance contribution for three (3) months. The resignation is considered to have taken place at the end of the month in which notice was given or during which the non-payment was detected.

An Other Insured person who has resigned from the fund does not have the right to rejoin the fund as an insured person.

**Section 6**

An insured person who resigns from the fund is not entitled to any shares of the fund's assets.

## INSURANCE CONTRIBUTIONS AND OTHER CONTRIBUTIONS

**Section 7**

The fund's insurance contribution is 1.6 per cent of the salary that the insured receives from their employer according to the Tax Prepayment Act (1118/1996), however, at maximum EUR 59.66 (2023) per month. No insurance contributions are collected on the holiday pay and holiday bonus paid when the employment relationship ends.

The insured's maximum insurance contribution is tied to the wage coefficient defined in sections 96, 97 and 100 of the Employees Pensions Act (395/2006) such that the euro amount in this section corresponds to the wage coefficient 1.558 (2023).

Persons on unpaid leave (e.g. job alternation leave, child-care leave, study leave or temporary lay-off) pay their own insurance contributions if they want to retain their right to the additional benefits specified in these rules. The insurance contribution of a person on unpaid leave is fixed and decided on annually in the November General Fund Meeting. For insured persons on unpaid leave, the right to additional benefits ends in the event of non-payment of the insurance contribution.

A pensioner's insurance contribution is 2.1 per cent of their pension income. The insurance contribution cap is the same as in the first subsection.

The insurance contribution for an Other Insured person is 2.1 per cent of their income subject to withholding tax. The insurance contribution cap is the same as in the first subsection.

**Section 8**

The employer withholds the insurance contribution from the insured's salary in connection with salary payment. The insurance contribution is remitted to the fund once a month.

Retired insured persons must provide the fund with the information required for determining the insurance contribution and pay their insurance contribution as instructed by the Board of Directors. The Board of Directors has the right to decide the amount of pension income to be used as the basis for the contribution if the insured fails to provide the fund with the necessary information for determining the contribution.

Other Insured persons must provide the fund with the information required for determining the insurance contribution and pay their insurance contribution as instructed by the Board of Directors.

Insured persons on unpaid leave must pay the fixed insurance contribution themselves to the sickness fund's account every month.

**Section 9**

If the fund's financial situation so requires, the fund's Board of Directors can increase or decrease the contributions defined in section 7 and the index-adjusted maximum amount of the insurance contribution by a maximum of 35 per cent. A change of fees for a period of more than six months, however, must be carried out as a rule amendment.

## OPERATIONS ACCORDING TO THE HEALTH INSURANCE ACT

**Section 10**

The insured are, according to the Health Insurance Act and the provisions based on it, entitled to receive:

1) compensation for expenses arising from necessary medical treatment of an illness;
2) daily allowance for a period of disability due to illness;
3) compensation for necessary expenses in connection with pregnancy and childbirth;
4) pregnancy and parental allowance, and special pregnancy allowance;
5) daily allowance according to the Act on the Medical Use of Human Organs and Tissues (101/2001), section 18.

**Section 11**

Benefits under the Health Insurance Act, their amounts and restrictions, commencement and expiry of the insurance, application for and payment of benefits, appeals and tasks related to operations according to the Health Insurance Act are defined as laid down in the Health Insurance Act and the provisions and regulations based on it.

**Section 12**

The fund is entitled to obtain from the health insurance fund of the Social Insurance Institution (Kela) the assets required for the payment of the benefits defined in the Health Insurance Act and compensation for its administrative expenses as regulated in the Health Insurance Act and the Government Decree on the implementation of the Health Insurance Act (1335/2004).

## ADDITIONAL BENEFITS

**Section 13**

Valid as of 1 August 2023
Approved by the General Fund Meeting
on 27 April 2023

Confirmed by the Financial Supervisory
Authority on 6 June 2023

The fund compensates expenses arising from necessary treatment if an insured person must turn to a doctor or another person with appropriate professional training for the treatment of an illness, pregnancy or childbirth.

Compensation is paid to the extent of expenses that would have been incurred by the insured for treatment where unnecessary costs are avoided without endangering the insured's health.
Compensation is not paid for the cost of fertility treatments or for artificial kidney and cancer treatments carried out by a private service provider.

In these rules, dentists are also considered doctors.

Before payment, a deduction is made to the compensation according to section 16.

**Employed insured persons are paid compensation as follows:**

1. 70 per cent of the doctor's fee for an appointment that is also compensable under the Health Insurance Act if the treatment was necessary to cure an illness other than a dental one, with the exception of, however, fees for an operation or a comparable procedure, unless the Board of Directors, in an individual case, considers it reasonable to compensate the fee either in full or in part in accordance with the Board's annually confirmed guidelines; and

2. public sector customer fees other than dental care fees; an additional benefit is compensated up to the maximum limit specified in the Decree on Client Fees in Social Welfare and Healthcare (912/1992). The following are compensated as public sector customer charges:
- hospital outpatient clinic fees
- health centre fees
- serial treatment fees
- A-clinic appointment fees
- day surgery fees
- in-patient fees for a maximum of 80 days per calendar year for the same illness
- day hospital fees
- at-home hospital fees; however, for 40 days per calendar year at maximum

b) 80 per cent of the daily fee defined above in subsection 2 a for the institutional care of substance abusers for a maximum stay of 80 days;
c) fees for care in a private medical facility, to be compensated either in full or in part, if considered reasonable by the Board in individual cases and if the costs of the treatment are not otherwise covered by subsections 1–9; and

3. doctor-prescribed medication, clinical nutritional supplements, products corresponding to these and basic creams when compensation has also been granted based on the Health Insurance Act such that the compensation is calculated based on the price used to calculate the compensation under the Health Insurance Act;
compensation of the initial deductible according to the Health Insurance Act is decided on by the General Fund Meeting held in November;
compensation is not paid for medications intended for fertility treatments; and

4. 70% of laboratory analyses and radiological and pathological examinations prescribed by a doctor to treat or diagnose an illness, with the following exceptions:

- MRI, CT, PET-CT, gamma and CBCT scans require a referral from a specialist doctor
- Prenatal ultrasound scans are not compensated
- Examinations related to fertility treatments are not compensated

Not reimbursed, however, are other procedures carried out in connection with these examinations, unless the Board considers it reasonable in individual cases to compensate these costs in full or in part; 70 percent of the facility fee collected in connection with the aforementioned examinations is reimbursed, however, up to a maximum of EUR 100; and

5. a) 70 per cent of the physiotherapy and physiotherapeutic examinations prescribed by a doctor for the treatment or diagnosis of an illness, however, up to a maximum of 12 treatment sessions per calendar year;
b) 70 per cent of psychotherapy recommended by a doctor, however, up to a maximum of 8 treatment sessions per year;
c) massage treatment given by a licensed massage therapist is compensated according to the compensation confirmed by the Board in the November General Fund Meeting;
d) 70 per cent of foot care prescribed by a doctor; foot care compensation covers up to three treatment sessions with a podiatrist per calendar year;
e) the cost of phototherapy prescribed by a doctor is compensated up to the maximum amount of EUR 300 per calendar year;

Compensation is not paid for fertility treatments or for cancer and artificial kidney treatments carried out by a private service provider.

The fund's Board is responsible for providing more detailed guidelines concerning subsections 5a, 5b, 5c and 5d.

6. a) travel expenses incurred by a fund's insured as specified in the guidelines given by the Fund's Board that are necessary for receiving medical treatment or for procuring and maintaining aids or other equipment prescribed by a doctor, using the cheapest means of transport, unless the nature of the illness or traffic conditions are considered to require other means of transport;
b) travel expenses resulting from visits to the patient by a doctor or other person with appropriate professional training as defined in section 14, subsection 1, and
c) necessary accommodation expenses as specified in the guidelines given by the fund's Board, in cases where the fund's insured, during a reimbursable journey, has had to stay overnight in a commercial accommodation establishment or an accommodation provided for patients of a research or medical institution; and

7. the cost of acquiring aids, prescribed by a doctor and in accordance with the Board's guidelines, up to a maximum amount of EUR 170 per calendar year in cases where these items cannot be permanently or temporarily obtained free of charge and with the fund's liability being limited to the amount from which other possible reimbursements or discounts have been deducted; and

8. a) eyeglasses prescribed by a doctor or an optician are reimbursed up to:

- EUR 110 if the sickness fund insurance relationship has lasted at least one (1) year, or if one (1) year has elapsed since the previous eyeglasses were purchased.
- EUR 225 if the sickness fund insurance relationship has lasted at least two (2) years, or if two (2) years have elapsed since the previous eyeglasses were purchased.
- EUR 340 if the sickness fund insurance relationship has lasted at least three (3) years, or if three (3) years have elapsed since the previous eyeglasses were purchased.
- EUR 450 if the sickness fund insurance relationship has lasted at least four (4) years, or if four (4) years have elapsed since the previous eyeglasses were purchased.

The condition for compensation is that the lenses of the eyeglasses are ground optically to correct eyesight;

compensation for new eyeglasses can be paid again if the compensation interval stipulated in the rules has elapsed since the previous purchase and compensation of eyeglasses;
b) alternatively, a sum corresponding to the amount of compensation paid for eyeglasses can also be used for refractive surgery. The amounts of compensation and the conditions for the renewal of compensation are the same as with eyeglasses;

9. for a person that has belonged to the fund for at least one year, fees for treatment given by a dentist, a dental technician or, by a dentist's referral, a dental hygienist, with the exception of the fees or charges mentioned in paragraph 1. The treatment also includes dental examination, orthodontics, dental prosthetics and technical dental work. The costs arising from treatment given during a calendar year are compensated up to the maximum amount of EUR 300 as an additional benefit. The maximum amount of compensation for prosthetic treatment is double the usual compensation, however, such that the fund's insured person will have no right to compensation for dental treatment during the calendar year following the year in which the compensation was paid; and

**Insured pensioners and Other Insured persons are paid compensation as follows:**

1. 60 per cent of the doctor's fee for an appointment that is also compensable under the Health Insurance Act if the treatment was necessary to cure an illness other than a dental one, with the exception of, however, fees for an operation or a comparable procedure, unless the Board of Directors, in an individual case, considers it reasonable to compensate the fee either in full or in part in accordance with the Board's annually confirmed guidelines; and

2. a) public sector customer fees other than dental care fees. An additional benefit is compensated up to the maximum limit specified in the Decree on Client Fees in Social Welfare and Healthcare (912/1992). The following are compensated as public sector customer charges:
- hospital outpatient clinic fees
- health centre fees
- serial treatment fees
- A-clinic appointment fees
- day surgery fees
- in-patient fees for a maximum of 100 days for the entire pension insurance period for the same illness
- day hospital fees
- at-home hospital fees; however, for 40 days per calendar year at maximum

b) 80 per cent of the daily fee defined above in subsection 2.a for the institutional care of substance abusers for a maximum stay of 80 days;

c) fees for care in a private medical facility, to be compensated either in full or in part, if considered reasonable by the Board in individual cases and if the costs of the treatment are not otherwise covered by subsections 1–9; and

3. doctor-prescribed medication, clinical nutritional supplements, products corresponding to these and basic creams when compensation has also been granted based on the Health Insurance Act such that the compensation is calculated based on the price used to calculate the compensation under the Health Insurance Act.

Compensation of the initial deductible according to the Health Insurance Act is decided on by the General Fund Meeting held in November; and

4. 60% of laboratory analyses and radiological and pathological examinations prescribed by a doctor to treat or diagnose an illness, with the following exceptions:

- MRI, CT, PET-CT, gamma and CBCT scans require a referral from a specialist doctor

Not reimbursed, however, are other procedures carried out in connection with these examinations, unless the Board considers it reasonable in individual cases to compensate these costs in full or in part; the facility fee collected in connection with the aforementioned examinations is a maximum of EUR 50; and

5. a) 50% of physiotherapy and physiotherapeutic examinations prescribed by a doctor, however, up to a maximum of 8 treatment sessions per calendar year;

b) 50 per cent of psychotherapy recommended by a doctor, however, up to a maximum of 4 treatment sessions per year;

c) massage treatment given by a licensed massage therapist is compensated according to the compensation confirmed by the Board in the November General Fund Meeting;

d) 70 per cent of foot care prescribed by a doctor. Foot care compensation covers up to three treatment sessions with a podiatrist per calendar year;

e) the cost of phototherapy prescribed by a doctor is compensated up to the maximum amount of

EUR 150 per calendar year; Compensation is not paid for cancer and artificial kidney treatments

carried out by a private service provider.

The fund’s Board is responsible for providing more detailed guidelines concerning subsections 5.a, 5.b, 5.c and 5.d.

6.a) travel expenses incurred by a fund's insured as specified in the general guidelines given by the Fund's Board that are necessary for receiving medical treatment or for procuring and maintaining aids or other equipment prescribed by a doctor, using the cheapest means of transport, unless the nature of the illness or traffic conditions are considered to require other means of transport;
b) travel expenses resulting from visits to the patient by a doctor or other person with appropriate professional training as defined in section 14, subsection 1, and
c) necessary accommodation expenses as specified in the general guidelines given by the fund's Board, in cases where the fund's insured, during a reimbursable journey, has had to stay overnight in a commercial accommodation establishment or an accommodation provided for patients of a research or medical institution;

7. the cost of acquiring aids, prescribed by a doctor and in accordance with the Board's guidelines, up to a maximum amount of EUR 100 per calendar year in cases where these items cannot be permanently or temporarily obtained free of charge and with the fund's liability being limited to the amount from which other possible reimbursements or discounts have been deducted; and

8. a) eyeglasses prescribed by a doctor or an optician are reimbursed up to:

- EUR 55 if one (1) year has elapsed since the previous eyeglasses were purchased.
- EUR 110 if two (2) years have elapsed since the previous eyeglasses were purchased.
- EUR 205 if three (3) years have elapsed since the previous eyeglasses were purchased.
- EUR 290 if four (4) years have elapsed since the previous eyeglasses were purchased.

The condition for compensation is that the lenses of the eyeglasses are ground optically to correct eyesight; compensation for new eyeglasses can be paid again if the compensation interval stipulated in the rules has elapsed since the previous purchase and compensation of eyeglasses; alternatively, a sum corresponding to the amount of compensation paid for eyeglasses can also be used for refractive surgery; the amounts of compensation and the conditions for the renewal of compensation are the same as with eyeglasses; and

9. expenses for dental care are compensated up to a maximum of EUR 190 per calendar year. The maximum amount of compensation for prosthetic treatment is double the usual compensation, however, such that the fund's insured person will have no right to compensation for dental treatment during the calendar year following the year in which the compensation was paid.

**Section 14**

The person carrying out the examination or providing the treatment according to these rules must have received appropriate professional training and be entered in Valvira's (the licensing and supervisory authority operating under the Ministry of Social Affairs and Health) central register of professionals, or the examination or treatment must take place in a private health-care unit as referred to in the Private Health Care Act (152/1990).

Treatment given by a chiropractor, naprapath, osteopath, podiatrist and psychotherapist is only compensated if the person giving the treatment is entered in the register of Valvira, the licensing and supervisory authority operating under the Ministry of Social Affairs and Health.

Examinations and treatment are considered necessary if they are medically generally accepted and conform to the principles of good clinical practice. A medical prescription must be obtained prior to the occurrence of an event entitling to compensation. The prescription entitles to compensation within a period of one year upon its issue. Medicines, nutritional preparations and basic creams can be compensated at one time only in such quantities as are needed for a treatment period of three months.

Treatment provided abroad is compensated up to the maximum amount that such treatment would have cost in Finland. No compensation is paid for travel expenses abroad.

The General Fund Meeting can decide to make a cost-of-living index adjustment to the additional benefits which have a maximum amount laid down in the rules, to take effect as of the beginning of the next year.

**Section 15**

Upon the death of an insured, EUR 600 is paid as a funeral grant. Upon decision of the November General Fund Meeting, the amount of the funeral grant can be adjusted, as of the beginning of the following year, to reflect the change in the value of money during the General Fund Meeting year.

If the insured was married or had a common-law spouse at the time of their death, the funeral grant is paid to the spouse or common-law spouse, otherwise to the children or, if there are no children, to the insured's parents or, if neither of them is alive, to the estate of the deceased. If there is reason to assume that the person entitled to the grant will not take care of the funeral arrangements, the Board can decide that the grant shall first of all be used to refund no more than the actual funeral expenses to the person who has taken care of the funeral arrangements.

The provision above in subsection 2 regarding marriage and common-law marriage and the spouse and common-law spouse also applies to a registered partnership and registered partners as referred to in the Act on Registered Partnerships (950/2001).

Upon the death of a retired or Other Insured person, no funeral grant is paid.

**Section 16**

The benefits specified above in section 13 can be paid by the fund only if and insofar as they exceed the corresponding compensations to be paid according to the Health Insurance Act. If the fund's insured is entitled to receive compensation under Finnish laws other than the Health Insurance Act they shall be paid compensation only in the amount that exceeds the compensation paid under the other laws. Correspondingly, if the insured is entitled to compensation under the legislation of a country other than Finland, this compensation can, at the discretion of the Board, be taken into account in full or in part when determining the amount of compensation to be paid by the fund.

**Section 17**

The fund's liability with regard to additional benefits begins when the insurance relationship begins and ends when the insurance relationship ends, with the exception of the additional benefits specifically mentioned in section 13, for which the claims liability begins once the insurance relationship has lasted for the specified amount of time. The fund only compensates expenses incurred during the insurance relationship. The compensation of hospital fees ends with the end of the maximum period defined in section 13.

Costs are considered to arise when the treatment is provided or the examination is performed. In terms of the maximum annual compensation amounts, the grounds for compensation are determined based on the date and time of treatment, regardless of when the expenses have been paid.

## RESTRICTIONS CONCERNING ADDITIONAL BENEFITS

**Section 18**

If an insured person falls ill during a work stoppage or a temporary lay-off due to a lack of work or during an absence from work due to reasons other than illness or childbirth and the person does not receive pay during this period and does not pay the insurance contribution themself while on unpaid leave, the insured person is not paid additional benefits under section 13 of these rules for the period in question.

However, in situations as mentioned above in subsection 1, compensation according to section 13 can be paid from the contingency reserve at the discretion of the Board.

**Section 19**

If, after the occurrence of an insured event, the insured person has deceitfully given the fund false or incomplete information of importance for the payment or the amount of the additional benefit, the benefit may be reduced or refused insofar as is reasonable under the circumstances.

**Section 20**

As far as additional benefits are concerned, the fund has no liability towards an insured or other beneficiary who has wilfully caused an insured event.

If an insured or other beneficiary has caused the insured event through gross negligence, their benefit can be refused or reduced or the payment of an already granted benefit can be discontinued, insofar as is reasonable under the circumstances.

The provisions of subsection 2 also apply if an insured has wilfully prevented the restoration of their health or has without good reason refused the examination or treatment prescribed by a doctor authorised by the fund, with the exception of procedures causing a considerable health risk. Before refusing or reducing a benefit or discontinuing the payment of a granted benefit, the insured or the beneficiary must be heard, and the conduct of the insured or the beneficiary in the matter and the amount of the paid benefit must be taken into account.

**Section 21**

The Board is entitled to determine in the guidelines which doctor or person with appropriate professional training as defined in section 14, subsection 1, and which research or medical institution or pharmacy shall be used as far as compensation of treatment as an additional benefit under these rules is concerned.

The insured is obliged, by order of the fund's Board, to visit a doctor or a research or medical institution stipulated by the Board in order to be examined in connection with their compensation claim at the expense of the fund.

If the insured does not follow the Board's order based on subsection 1 or 2, the compensation can be refused in full or in part.

## APPLYING FOR AND PAYMENT OF ADDITIONAL BENEFITS

**Section 22**

Additional benefits under these rules must be applied for in writing. In the application or appendix thereto, information that the fund considers necessary to estimate the insurance fund's claims liability must be provided.

Compensation for expenses resulting from illness or pregnancy and childbirth shall be applied for within six (6) months after the expenses to be compensated have been paid.

Funeral grants must be applied for within one (1) year after the event. If the application is delayed, the benefit can still be granted in full or in part if a refusal would seem unreasonable.

Benefit applications shall be dealt with as urgent. If a benefit is late, the provisions of Chapter 6, section 8 of the Employee Benefit Funds Act apply.

**Section 23**

Compensation under section 13 of these rules can, notwithstanding the provisions of section 16, be paid in full if the payment of other compensation referred to in the latter section is delayed for reasons beyond the control of the insured, provided that the insured undertakes to repay to the fund, from the amount of compensation that they received pursuant to the law, the portion that corresponds to the compensation paid by the fund.

**Section 24**

If an insured or another beneficiary has under these rules received more additional benefits than they are entitled to, the unduly paid benefits shall be recovered.

The recovery of an unduly paid additional benefit can be overlooked in part or in full if this is considered reasonable and if the payment of the benefit cannot be regarded as the result of deceitful conduct on the part of the insured person or beneficiary or their representative or if the amount to be repaid is minimal.

An unduly repaid additional benefit can also be recovered by setting it off against future benefit payments.

## APPEAL AGAINST A DECISION ON ADDITIONAL BENEFITS

**Section 25**

Persons dissatisfied with the fund's decision on additional benefits can request a settlement recommendation from the Finnish Financial Ombudsman Bureau (FINE). The settlement recommendation request must be sent to the person's own fund or to FINE within 30 days of when the insured person was notified of the decision. The insured person is deemed to have been notified of the decision on the seventh day from the date when the decision was posted.

Anyone dissatisfied with a decision concerning an additional benefit can also bring the matter before a court. The legal action must be taken within three years of when the party dissatisfied with the additional benefit decision was notified in writing of the decision and the three-year timeframe. The court is the court of first instance of the fund's domicile, i.e. the District Court of Itä-Uusimaa. The action can also be brought before the district court in whose jurisdiction the claimant has their domicile or normal place of residence.

## EQUITY RESERVES

**Section 26**

The fund has a legal reserve and a contingency reserve.

The legal reserve shall annually be increased by at least 20 per cent of the profit recognised in the balance sheet less the losses from previous financial periods recognised in the balance sheet.

When the legal reserve is at least as large as the average premium income of the financial period and the two previous periods, the transfer to the legal reserve is no longer obligatory.

The legal reserve may be reduced, upon decision of the General Fund Meeting, only in order to cover losses recognised in the balance sheet.

Notwithstanding what is stipulated in subsection 4, the Financial Supervisory Authority can, on application, give the fund permission to reduce the legal reserve for special reasons, generally not, however, to an amount smaller than the amount of the full legal reserve.

**Section 27**

The part of the profit that is not transferred to the legal reserve shall be transferred to the

contingency reserve. The contingency reserve may be used:

1) to primarily cover losses recognised in the balance sheet;
2) to increase, at the discretion of the Board, benefits under sections 13–15 according to a plan approved by the Board for a maximum period of one year at a time; and
3) for the purpose mentioned in section 18, subsection 2.

If the contingency reserve has become so large that it exceeds the amount of the full legal reserve by more than 30 per cent, the fund shall take measures either to increase the additional benefits under these rules or to lower the premiums.

## TECHNICAL PROVISIONS

**Section 28**

The fund’s technical provisions consist of a provision for claims outstanding, which corresponds to claims payable due to insured events and other amounts still unpaid.

The provision for claims outstanding is calculated in the financial statements according to the calculation principles issued by the Financial Supervisory Authority.

## FINANCIAL STATEMENTS AND REPORT OF THE BOARD OF DIRECTORS

**Section 29**

The fund’s financial period is the calendar year.

For each financial period, financial statements shall be prepared in accordance with the Decree of the Ministry of Social Affairs and Health (1196/2021) and the regulations of the Financial Supervisory Authority, consisting of a profit and loss account and a balance sheet including notes.
A report of the Board of Directors shall be appended to the financial statements. The financial statements shall be submitted to the auditors at least one month before the General Fund Meeting.

**Section 30**

If the contingency reserve is not sufficient to cover the fund's losses, the legal reserve will be

used for this purpose. The fund is not subject to the obligation to contribute referred to in

Chapter 4, section 12 of the Employee Benefits Funds Act.

## AUDITING

**Section 31**

The fund shall have two auditors who are elected for one calendar year at a time. The auditor can be a natural person or an approved audit firm. If the auditor is a natural person, a deputy auditor shall be elected. If the auditor is an audit firm, no deputy auditor shall be elected

The auditor and the deputy auditor must be auditors as referred to in the Auditing Act (1141/2015).

**Section 32**

The auditors must, to the extent required by good auditing practice, audit the fund's financial statements and its accounting records and administration and, for each financial period, submit an auditors' report to the Board.

## GENERAL FUND MEETING

**Section 33**

The supreme decision-making power in fund matters rests with the General Fund Meeting in which all of the fund's insured are entitled to participate and exercise their right to be heard. Upon separate decision by the Board, participation in the Meeting is also possible by post, a telecommunications

connection or other technical aid.

The General Fund Meeting shall be held at the fund’s domicile.

**Section 34**

Each insured has one (1) vote in the General Fund Meeting. The insured can exercise their vote at the Meeting in person or through a representative. The representative must also be insured in the fund and is entitled to represent a maximum of one (1) insured person.

The representative of an insured person must present a dated special power of attorney.

**Section 35**

The fund annually holds two General Fund Meetings, one no later than in April and one no later than in November.

The General Fund Meeting held no later than in April:

1) presents the financial statements and the auditors' report;
2) decides on the adoption of the financial statements for the previous year;
3) decides on the discharging of the Board members and the Managing Director from liability;
4) decides on the disposal of profit/the covering of losses;
5) decides on other measures required by the operations and financial statements of the previous year;
6) addresses other matters possibly mentioned in the notice of meeting.

The General Fund Meeting held no later than in November:

1) determines the remuneration of the Chairman, the Board members and the auditors;
2) elects Board members and deputy members to replace Board members and deputy members with expiring terms;
3) elects the auditors and, if necessary, deputy auditors; and
4) addresses other matters possibly mentioned in the notice of meeting.

**Section 36**

An Extraordinary Fund Meeting shall be held when the Board considers it necessary.

An Extraordinary Fund Meeting shall furthermore be held if the persons with more than one tenth of the total votes of those entitled to vote at the Meeting or the Financial Supervisory Authority or the auditor of the fund demand so in writing for a notified matter.

The notice of meeting shall be delivered within 14 days after the demand referred to in subsection 2 has been presented.

**Section 37**

The notice of the General Fund Meeting shall be delivered no earlier than four weeks and no later than one week before the Meeting.

If the decision on a matter discussed at the General Fund Meeting is adjourned to a continued meeting, a separate notice shall be delivered if the meeting is to take place after more than four weeks.

The notice of meeting and other disclosures of the fund shall be delivered through a notification to be posted on the fund's website and on the employers' intranet, where possible.

**Section 38**

The issues to be discussed at the General Fund Meeting shall be specified in the notice.

If the financial statements are discussed at the General Fund Meeting, the relevant documents or copies of them must be made available at the fund's office to the persons entitled to vote no less than a week before the meeting. The documents must also be available for review at the Fund Meeting. The same applies if an issue concerning an amendment to the rules is to be discussed at the General Fund Meeting. The availability of the documents must be mentioned in the notice of meeting.

If an amendment to the fund's rules is to be discussed at the General Fund Meeting, the main content of the amendment shall be described in the notice of meeting.

**Section 39**

The General Fund Meeting shall be chaired by the person who has been elected for this task by the Meeting.

The opinion that is supported by more than half of the votes cast shall become the decision of the General Fund Meeting, unless Finnish law or these rules stipulate otherwise. If the votes are cast equally, the chairman shall have the casting

vote. The person who receives the highest number of votes in the elections shall be considered as elected. If the votes are cast equally, the decision shall be made by lot.

A decision concerning an amendment to the fund's rules shall be valid only if supported by at least two thirds of the votes cast.

The same applies to the setting into liquidation and the dissolution of the Fund in cases other than those prescribed by the law, and to the approval of agreements concerning a merger.

**Section 40**

If the Pension Funds Act's provisions regarding the procedures to be followed or the provisions of these rules concerning the notice of meeting were not followed when discussing a matter, a decision on the matter can only be made if the insured persons that the neglect concerns give their consent to it. If a matter, according to the law or these rules, is to be addressed at the General Fund Meeting, the Meeting can make a decision on it even if the issue was not mentioned in the notice.
The General Fund Meeting can also always decide to convene an Extraordinary Fund Meeting to deal with a specific issue.

An insured has the right to bring a matter of their choosing to the Meeting for discussion, provided that they present a written demand to the Board early enough for the matter to be included in the notice of meeting.

**Section 41**

At the General Fund Meeting, minutes shall be kept, recording the persons present and entitled to vote and their votes, the decisions made at the Meeting and the time and the results of the voting. The minutes shall be examined and signed by the Chairman and by at least two (2) other persons elected for this purpose at the General Fund Meeting. The minutes shall be numbered sequentially and stored in a reliable manner. The minutes shall be made available to the fund's insured persons at the fund's office no later than two weeks after the Meeting.

## BOARD OF DIRECTORS

**Section 42**

The fund's Board of Directors consists of five ordinary members, each of whom shall have a personal deputy.

The Board of Directors is elected by the General Fund Meeting.

A Board member's term of office is two calendar years and, in the first year, two members with their deputies and, in the second year, three members with their deputies shall resign from the Board of Directors.

The Board's Chair and Deputy Chair are paid a monthly fee, the amount of which is decided by the Fund Meeting. The amount of the meeting fees paid to the Board members is decided by the Fund Meeting.

**Section 43**

The Board of Directors represents the fund and handles its administration and the proper organisation of its operations.

In particular, the Board of Directors has the task of:

1) appointing and dismissing the Managing Director and the fund's employees, and determining the conditions of their employment;

2) giving the Managing Director the instructions and orders necessary for the proper handling of the routine administration and other operations;

3) ensuring the appropriate organisation of the control of the fund's accounting and finance;

4) deciding on the investment of the fund's assets and on taking out loans;

5) deciding on the granting of benefits, unless the Board has authorised the Managing Director or the fund's employees to make decisions;

6) convening the General Fund Meeting and preparing the issues to be dealt with at the Meeting as well as presenting to the Meeting in its report a proposal of measures concerning the profit/loss recognised in the financial statements; and

7) giving the right to sign the name of the fund.

**Section 44**

The Board elects a Chair and a Deputy Chair from among its members each year. The Managing Director or the actuary cannot act as the Chair of the Board of Directors.

The Board of Directors is convened by the Chair, or, when the Chair is prevented from attending to their duties, by the Deputy Chair. The Chair must convene a meeting of the Board of Directors at the request of a Board member or the Managing Director. The

meeting of the Board of Directors can also be attended using a telecommunications connection or other technical aid during the meeting, if the Board so decides when convening the meeting.

The Board of Directors constitutes a quorum when the Chair or Deputy Chair and at least 2 other members are present.

The Board of Directors' decision shall be the opinion supported by more than half of those present. If the votes are cast equally, the Chair shall have the casting vote.

A member of the Board or the Managing Director may not take part in the handling of any issue concerning their relationship with the Fund or otherwise their personal interest.

**Section 45**

Minutes shall be kept of the Board of Directors' meetings, and the minutes shall be signed by the Chair of the meeting and the drafter of the minutes. The minutes shall be checked by at least one member specially elected by the Board for each particular meeting.

A member of the Board and the Managing Director have the right to have their dissenting opinions noted in the minutes. The minutes shall be numbered sequentially and stored in a reliable manner.

The following shall be recorded in the minutes:

1) the date and place of the meeting and its starting and ending time;
2) the Board members and other persons present at the Meeting;
3) the issues addressed at the Meeting, the decisions made, the votes cast and the dissenting opinions voiced; and
4) cases of disqualification from decision-making and other matters considered necessary.

## MANAGING DIRECTOR

**Section 46**

The Managing Director's task is to manage the fund's day-to-day administration in accordance with the instructions and orders given by the Board. The Managing Director shall ensure that the accounts of the fund are in compliance with the law and that its financial affairs have been arranged in a reliable manner.

The Managing Director has the right to represent the fund in matters which are part of their responsibility according to Chapter 4, section 13 of the Pension Funds Act.

## SIGNATURE OF THE FUND

**Section 47**

The fund's name shall be signed by a member of the Board, the Managing Director or a member of the fund's clerical staff authorised by the Board, two jointly.

## INVESTMENT OF ASSETS AND TAKING OUT LOANS

**Section 48**

The fund shall invest its assets in a secure and profitable manner, keeping liquidity in mind. The fund's assets shall not be used for purposes outside the fund's sphere of operations.

The fund shall adapt its operations such that the operations are possible without taking on debt. However, the fund may temporarily take out short-term loans to maintain liquidity. The fund must not provide guarantees.

## CHANGES TO EMPLOYER'S OBLIGATIONS

**Section 49**

If the employer wishes to revoke obligations laid down in these rules, the fund must be notified thereof in writing at least six months before the change enters into effect.

After having received the notice referred to in subsection 1, the fund must take immediate action to implement the required changes.

## MERGER AND DEMERGER

**Section 50**

The fund cannot merge or demerge in the manner provided for in Chapter 7 of the Employee Benefits Funds Act.

## INSURANCE PORTFOLIO TRANSFER AND VOLUNTARY LIQUIDATION AND DISSOLUTION OF THE FUND

**Section 51**

Regarding the transfer of the fund's insurance portfolio and voluntary liquidation and dissolution of the fund and the measures required by them, the provisions of Chapter 8 of the Employee Benefits Funds Act shall be followed.

## STATUTORY LIQUIDATION AND DISSOLUTION

**Section 52**

Regarding the statutory liquidation and dissolution of the fund and the measures required by them, the provisions of Chapter 9 of the Employee Benefits Funds Act shall be followed.

The fund shall be placed into liquidation and dissolved:

1) if the number of insured persons at the end of the previous two calendar years did not meet the minimum prescribed under these rules and it cannot be considered likely that the number will increase above the aforementioned number within the next four months;
2) if the fund's financial statements show a loss which remains uncovered during the next two financial periods; and
3) if the fund does not meet the criteria for calculating the technical provisions or the requirements concerning the covering of technical provisions and the segregation of the cover;
4) if all its stakeholders cease their operations in which sphere the insured persons work;
5) if separately stipulated in the rules;
6) if the Financial Supervisory Authority has ordered the fund to be dissolved.

**Section 53**

When the fund is dissolved, the remaining assets shall be distributed among those who were insured in the

fund when the liquidation process began. The assets shall be distributed in proportion to the insurance contributions paid during a period of 60 months immediately prior

to the start of the liquidation. If the distributable amount is minimal, the General Fund Meeting can decide with a two-thirds majority of the votes that the assets shall be used for another purpose corresponding to the operations of the Fund or for non-profit purposes.