ENERKEMI INSURANCE FUND RULES

Effective from 1 July 2024

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GENERAL REGULATIONS

1 The name of the fund is the Enerkemi Insurance Fund. The fund is domiciled in Espoo.

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

In addition to these rules, the Act on Pension Foundations and Pension Funds (946/2021) and the Act on Public Insurance Funds (948/2021) apply to the operations of the fund.

The Financial Supervisory Authority is responsible for the general supervision of the fund. The fund's operations in accordance with the Health Insurance Act are supervised by the Social Insurance Institution of Finland.

3 There must be at least 300 insured persons in the fund.

SPHERE OF OPERATIONS AND INSURANCE RELATIONSHIP

4 The fund's sphere of operations consists of persons in an employment relationship with the companies mentioned in the stakeholder register. Any company-specific limitations to belonging to the sphere of operations are mentioned in the stakeholder register. In these rules, a company is referred to as a stakeholder.

The stakeholder register is public and available on the fund's website.

For a person to belong to the sphere of operations, they must receive their primary income from a stakeholder.

Limitations to belonging to the sphere of operations:

a) People whose employment relationship is intended to be temporary and short term are excluded from the sphere of operations. A person who enters into a fixed-term employment relationship is accepted as insured by the fund if the insurance relationship will last at least six months.
b) The following individuals are excluded from the sphere of operations: those enjoying a full statutory old-age pension, those enjoying a supplementary pension paid by a pension fund, those enjoying a pension paid by their employer under pension insurance, and those enjoying full rehabilitation benefits or a full disability pension. The limitation also concerns people who continue to work for a

stakeholder company under a new contract after the beginning of their pension.

c) Persons insured by another sickness or insurance fund are excluded from the sphere of operations.

Individuals covered by the fund's sphere of operations are entitled to join the fund as insured persons. The insurance relationship is voluntary.

Insurance must be applied for within six months of the beginning of the employment relationship. If the conditions for insurance are met, the insurance relationship starts at the beginning of the month following the application.

When an insured person enters the employment of another stakeholder company directly within the sphere of operations, the insurance relationship is maintained with the fund if the inclusion in the sphere of operations is not specifically limited in the stakeholder register for the new employer. The change of employers must be reported to the fund.

By means of a separate decision for a specific period of time, the Board of Directors may enable insurance relationship applications for people under an employment relationship with a stakeholder who have not previously been members of the fund.

At the beginning of the insurance relationship, the fund's rules are submitted to the insured person by email or post. Insured persons are informed about the regulations and any changes to the rules on the insurance fund's website.

A stakeholder is obligated to notify the fund's Board of Directors of corporate transactions, so that the prerequisites for belonging to the stakeholder's sphere of operations after the change can be assessed.

RESIGNATION AND DISMISSAL FROM THE FUND

5 An insured person resigns from the fund when they are no longer covered by its sphere of operations or when they file written notification with the fund of their resignation.

The insurance relationship ends from the beginning of the calendar month following the termination of the employment relationship or the notice of resignation.

An insured person can only be dismissed from the fund in accordance with section 18 of these rules.

A person who has resigned from the fund even though their employment relationship has not ended is not entitled to rejoin the fund. A resigned insured person is not entitled to a new insurance relationship even if they transfer directly to the employment of another stakeholder within the sphere of operations.

6 Stakeholders resign from the fund by notifying the fund of their resignation in writing no later than 12 months before the date of resignation.

Stakeholders cannot be dismissed from the fund.

7 An insured person or a stakeholder who resigns from the fund is not entitled to a share of its assets.

INSURANCE PREMIUMS

8 The fund membership fee is 0.31% of the salary paid to the insured person by a stakeholder company under the Prepayment Act, but no less than EUR 8.53 and no more than EUR 17.07 per month. The minimum and maximum insurance premium amounts are tied to a salary coefficient in accordance with sections 96, 97 and 100 of the Employees Pensions Act (395/2006), so that the euro-denominated amounts in this paragraph correspond to a salary coefficient of 1.363.

By way of derogation from the above, the insurance premium for insured persons employed by Caverion Industria Oy, Caverion Suomi Oy, Elcoline Industria Service Oy, Elcoline Plant Service Oy, Elcoline Power Oy and Turku Energia Oy is 0.676% of the salary received by the member from the stakeholder under the Prepayment Act, but no less than EUR 18.65 and no more than EUR 37.29 per month. The minimum and maximum insurance premium amounts are tied to a salary coefficient in accordance with sections 96, 97 and 100 of the Employees Pensions Act (395/2006), so that the euro-denominated amounts in this paragraph correspond to a salary coefficient of 1.363.

A stakeholder's insurance premium is 218% of the total amount of the insurance premiums of the insured persons employed by the stakeholder.

By way of derogation from the above, the insurance premium of Caverion Industria Oy, Caverion Suomi Oy, Elcoline Industria Service Oy, Elcoline Plant Service Oy, Elcoline Power Oy and Turku Energia Oy is 45.9% of the total amount of the insurance premiums of the insured persons employed by them.

9 A stakeholder withholds the insurance premium from the insured person's salary in connection with salary payment. Insurance premiums are paid to the fund once a month. The insurance premium is not charged for periods of unpaid absence or assignments abroad.

The stakeholder's insurance premium is paid to the fund at the same time as the corresponding insurance premium of the insured person. Lists of premiums collected must be submitted to Enerkemi by the end of the month or, if this is not possible because of the payroll date, by the 15th of the following month.

10 If the financial position of the fund so requires, the Board of Directors may decrease or increase insurance premiums, as well as the index-adjusted minimum and maximum amounts, but by no more than 25%. Approval by the stakeholder for increases must be obtained before their implementation.

Changes to fees with a duration of more than six months must be implemented as changes to the rules.

OPERATIONS IN LINE WITH THE HEALTH INSURANCE ACT

11 In accordance with the Health Insurance Act and the regulations issued based on it, an insured person is entitled to the following:

1) Compensation for medical care expenses necessary for the treatment of an illness

2) Allowance based on medical incapacity for work

3) Compensation for necessary costs arising from pregnancy and childbirth

4) Maternity and special pregnancy allowance, as well as parental allowance and partial parental allowance

5) Daily allowance referred to in section 18 of the Act on the Medical Use of Human Organs, Tissues and Cells.

12 The following are determined in accordance with the Health Insurance Act and the regulations issued based on the Act: benefits under the Health Insurance Act and their amounts and limitations; the beginning and end of insurance; application for and payment of benefits; appeals; and duties related to operations in line with the Health Insurance Act.

13 The fund is entitled to receive, from the health insurance fund of the Social Insurance Institution of Finland, the assets for paying benefits under the Health Insurance Act, as well as compensation for the fund's administrative expenses in accordance with what is provided in the Health Insurance Act and the Government Decree on the Implementation of the Health Insurance Act (1335/2004).

ADDITIONAL BENEFITS

14 The fund compensates for expenses arising from necessary treatment to an insured person who must be treated by a doctor or other appropriately qualified professional because of illness, pregnancy or childbirth.

Compensation is paid to the extent that the treatment would have cost without any unnecessary expenses, without endangering the health of the member.

A deduction is made from the additional benefit in accordance with the Health Insurance Act or another act before its payment. Correspondingly, if an insured person is entitled to compensation based on the legislation of a country other than Finland, such compensation can be taken into account in full or in part when determining the compensation from the fund, based on the discretion of the Board of Directors.

REIMBURSABLE EXPENSES

14.1. Public healthcare

75% of public-sector customer fees. The maximum amounts of additional benefits are determined in accordance with the Decree on Client Fees in Social Welfare and Health Care (912/1992).

The following public-sector customer fees are reimbursed:

- Hospital outpatient clinic fees
- Public healthcare centre outpatient fees
- Serial treatment fees
- Detoxification unit fees
- Outpatient surgery fees
- Daily hospital fees for up to 100 days per calendar year
- Day hospital fees
- At-home hospital care and home care fees for up to 4 months per calendar year.
- Oral healthcare fees

14.2. Private healthcare

14.2.1 Doctors' fees

a) 75% of the doctor's appointment and opinion fees when the fee is also reimbursed in accordance with the Health Insurance Act. 75% of the facility fee charged in connection with a reimbursable appointment visit will be reimbursed.

b) 75% of the medical fees and the related facility fees for examinations

performed for the purpose of diagnosing or treating an illness.

c) 75% of the medical fees and the related facility fees for minor medical procedures, but no more than EUR 450 per procedure. The medical fee for more expensive surgery and comparable procedures is reimbursed in accordance with section 14.2.11.

No compensation is paid for the costs of infertility treatments or for artificial kidney and cancer treatments provided by a private service provider.

14.2.2 Dental care

75% of the fee of a dentist, dental technologist, dental nurse or dental hygienist, as well as imaging examinations prescribed by a dentist. Additional benefits are provided to individuals who have been members of the fund for a continuous period of at least one year. The maximum amount of an additional benefit is EUR 1,000 per insured person per calendar year.

14.2.3 Examinations in private healthcare

75% of laboratory examinations, examinations in the field of pathology and radiological examinations prescribed by a doctor or a dentist for the purpose of treating or diagnosing an illness, with the following exceptions and further specifications:

- A referral from a specialist is required for magnetic resonance imaging
- Compensation is not paid for ultrasound examinations during pregnancy
- No compensation is paid for examinations related to infertility treatments

The maximum amount of additional benefits based on examinations under this paragraph is EUR 1,000 per calendar year.

14.2.4 Physiotherapy, osteopathy, podiatry and chiropractic

75% of physiotherapy, osteopathy, naprapathy, podiatry and chiropractic prescribed by a doctor. The maximum amount of additional benefits based on treatment under this paragraph is EUR 900 per insured person per calendar year.

14.2.5 Treatment provided by a nurse

75% of the fees for care provided by a nurse, as well as the related facility and equipment fees, in connection with the treatment of an illness.

14.2.6 Psychotherapy and treatment provided by a psychologist, as well as medical statements for rehabilitation psychotherapy supported by Kela

75% of the fees for psychotherapy and treatment provided by a psychologist when there is a referral from a doctor. In addition, under this paragraph, compensation is paid for such

examinations ordered by a doctor or a psychologist that are not reimbursable under the Health Insurance Act, and for a doctor's opinion fees when the opinion is provided for rehabilitation psychotherapy supported by Kela.

Examinations reimbursable under the Health Insurance Act are reimbursed in accordance with section 14.2.3 of the fund's rules.

For couples therapy, half of the total costs are taken into account as the cost incurred by Enerkemi's insured person. The amount of compensation is calculated based on the portion regarded as the cost.

The maximum amount of additional benefits based on treatments and examinations under this paragraph is EUR 1,500 per insured person per calendar year.

14.2.7 Nutrition therapy

75% of nutrition therapy fees when there is a referral from a doctor or an occupational healthcare nurse. Additional benefits are paid for a maximum of three visits per calendar year.

14.2.8 Light therapy

75% of light therapy prescribed by a doctor for the treatment of a long-term skin disease.

14.2.9 Foot care for diabetes patients

75% of foot care for a diabetes patient prescribed by a doctor for a maximum of four treatment visits per calendar year.

14.2.10 Speech therapy

75% of treatment provided by a speech therapist when the treatment is prescribed by a doctor.

14.2.11 Operations and procedures

75% of operations and comparable procedures carried out by a private service provider. The maximum amount of additional benefits under this paragraph is EUR 1,500 per calendar year. All costs related to the same procedure are reimbursed on the basis of this paragraph.

It is advisable to apply for an advance decision on the eligibility of the treatment for compensation and for a voucher.

The compensation application must be accompanied by a description of the procedure to be carried out and the reasons for the procedure, as well as an estimate of the cost of the procedure. The fund's compensation liability applies to generally accepted medical treatment in accordance with good medical practice.

For some procedures, reimbursement will only be granted if specifically determined

medical conditions are met. Such further specified conditions apply to obesity surgery, acromion surgery, knee degeneration treatment by keyhole surgery, mammary surgery, gender-affirming surgery, varicocele surgery, upper eyelid surgery and cataract surgery. More detailed conditions for receiving compensation are provided on the fund's website.

No compensation is paid for infertility treatments or for cancer and artificial kidney treatments carried out by private service providers.

14.2.12 Substance abuse treatment

The fund pays additional compensation for substance abuse treatment and detoxification, unless the fund's medical specialist deems this unreasonable in an individual case. The compensation is up to 75% of the total cost.

14.3. Other reimbursable expenses

14.3.1 Pharmaceuticals

a) 75% of medicines, clinical nutritional and similar products and basic ointments prescribed by a doctor, a dentist or a healthcare professional with limited prescription rights when compensation has also been provided based on the Health Insurance Act. The compensation is calculated from the reference price.

   The initial deductible for medicines under the Health Insurance Act is not reimbursed. Medicines for the treatment of infertility are not reimbursed.

b) 75% of the medicines prescribed by a doctor or a dentist for the treatment of an illness that are not compensated for under the Health Insurance Act. The maximum amount of an additional benefit is EUR 670 per insured person per calendar year.

   The maximum amount to be reimbursed at a time is equal to a three-month period of treatment. The product being reimbursed for must be included in the medication database maintained by the Social Insurance Institution of Finland. Costs of medicines for the treatment of infertility are not reimbursed.

14.3.2 Aids

75% of the cost of the following aids when their purchase or lease is recommended by a doctor:

- Compression socks, compression vests and foot orthoses
- Joint supports for post-accident treatment for a period of up to three months

- Lease of a CPAP device at the beginning of treatment
- Expenses arising from acquiring a sleep apnoea orthosis
- Expenses arising from acquiring a hearing aid

The maximum amount of an additional benefit paid by the fund is EUR 500 per insured person per calendar year.

14.3.3 Glasses, opticians' fees, corrective eye surgery and monthly payments for service contracts for glasses, as well as prescription sunglasses

For a person who has been a member of the fund for at least one year without interruption, 75% of the price of glasses, sunglasses and contact lenses prescribed by a doctor or an optician, an optician's contact lenses fitting fee and eye examination fee, corrective eye surgery, or monthly payments for service contracts for glasses.

The maximum amount of additional benefits under this paragraph is EUR 550 per insured person per calendar year. To be eligible for compensation, the lenses must have been optically grinded to correct vision.

14.3.4 Medical expense insurance excess

If the insured person has been granted compensation on the basis of voluntary insurance, 75% of the excess is compensated for, but no more than EUR 100 per insured person per calendar year.

However, compensation in accordance with this paragraph is not paid for costs for which the insured has received or is entitled to receive compensation on the basis of other provisions of the fund's rules.

REQUIREMENTS FOR ADDITIONAL BENEFITS

15 The requirements for compensation under these rules are as follows:

1) The examination is performed or the treatment is provided by a doctor or other appropriately qualified professional who is included in the central register of healthcare professionals maintained by the National Supervisory Authority for Welfare and Health (Valvira).

2) In private healthcare, the examination or treatment is provided in a private health care unit within the meaning of the Act on the Supervision of Social Welfare and Health Care (741/2023).

Healthcare in accordance with generally accepted good medical practice is regarded as necessary treatment and examinations. A prescription from a doctor must be obtained before the reimbursable event. A prescription entitles its holder to compensation for a

period of one year from the date of the prescription. An individual prescription entitles its holder to compensation for a maximum of 15 examination or treatment visits if the examination is performed or the treatment is provided within one year of the date of the prescription.

Treatment provided abroad is reimbursed up to the price of similar treatment provided in Finland. Travel expenses abroad are not reimbursed.

By the decision of the Representative Council Meeting, the maximum compensation amounts provided in the rules can be adjusted from the beginning of the following May in accordance with the increase in costs during the year of the meeting.

PERIOD OF LIABILITY FOR THE FUND FOR ADDITIONAL BENEFITS

16 With regard to additional benefits, the liability of the fund starts at the beginning of the insurance relationship and ends at the termination of the insurance relationship.

The 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 time of treatment, regardless of when the expenses have been paid.

LIMITATIONS CONCERNING ADDITIONAL BENEFITS

17 Additional benefits in accordance with section 14 above are not paid for any period that an insured person is absent from work because of a work stoppage, layoff or other unpaid absence. As an exception to this, additional benefits are paid to insured persons who are entitled to daily allowance because of an illness or accident under the Health Insurance Act or other legislation. Benefits are paid on this basis for a maximum of one year from the beginning of the continuous incapacity for work. Additional benefits are also paid to insured persons on unpaid parental leave who receive Kela’s daily allowance.

Additional benefits are not paid for the period of an assignment abroad.

However, during layoffs and work stoppages, additional benefits can be paid from the contingency fund at the discretion of the Board of Directors.

If a benefit funded by the employer in part or in full (e.g. ePassi, Smartum) has been used to cover the costs, no additional benefits are paid based on the costs in accordance with these rules.

18 If an insured person has, after an insurance event, intentionally provided the fund with inaccurate or incomplete information that affects the provision or amount of additional benefits, they can be dismissed from the fund, or their benefits can be

denied or reduced in accordance with what the Board of Directors deems reasonable under the particular circumstances.

The Board of Directors of the fund can deny an insured person the right to additional benefits for a fixed period if the insured person fails to return additional benefits paid to them on incorrect grounds, as well as the related collection costs, immediately after having received a payment reminder. The right to additional benefits can be denied for a maximum period of two years at a time.

The fund may deduct amounts invoiced and overdue from compensation to be paid to an insured person.

19 In terms of additional benefits, the fund is free from liability towards an insured person who has intentionally caused an insurance event.

If an insured person has caused an insurance event out of gross negligence, their additional benefits can be denied or reduced, or the payment of benefits can be discontinued, in accordance with what the Board of Directors of the fund deems reasonable under the particular circumstances.

The procedure is the same if an insured person has deliberately prevented their healing, or has refused to attend an examination or treatment prescribed by a doctor designated by the fund, excluding procedures posing a severe health risk.

20 The Board of the fund has the right to determine which service provider must be used in the case of treatment to be compensated for as an additional benefit based on these rules.

An insured person has an obligation to attend an examination performed by a service provider designated by the Board at the expense of the fund if such an examination is required for a matter related to compensation.

If an insured person fails to comply with the provisions of paragraphs 1 or 2, their compensation can be denied in full or in part.

APPLICATION FOR AND PAYMENT OF ADDITIONAL BENEFITS

21 Additional benefits in accordance with these rules must be applied for in writing. The application or its appendix must provide the information that the fund deems necessary to assess the insurance fund's liability.

Additional benefits must be applied for within six months of paying the related fees. However, if the application is submitted later than that, benefits can be granted in full or in part by the decision of the Board of Directors if denying benefits can be regarded

as unreasonable.

Applications for benefits must be treated as urgent. The provisions of chapter 6, section 8 of the Public Insurance Funds Act apply to delayed benefits.

22 Compensation in accordance with section 14 of these rules can be paid in full if compensation under the Health Insurance Act or other legislation is delayed for a reason beyond the insured person's control and if the insured person agrees to refund the statutory compensation amount paid by the fund.

23 If an insured person or another beneficiary has received more additional benefits under these rules than the amount they are entitled to receive, the benefit paid on incorrect grounds must be refunded.

Additional benefits paid on incorrect grounds can be left uncollected from a member in part or in full if this is deemed reasonable and payment of the benefit is not deemed to have been based on insincere conduct by the insured person, beneficiary or their representative, or if the amount to be collected back is insignificant.

Additional benefits paid on incorrect grounds may also be recovered against additional benefits to be paid in the future.

APPEALING AGAINST ADDITIONAL BENEFIT DECISIONS

24 Insured persons dissatisfied with the fund's additional benefit decisions may request a recommendation from the Finnish Financial Ombudsman Bureau. Such insured persons must submit their request for a recommendation to their fund or the Finnish Financial Ombudsman Bureau within 30 days of having been informed of the decision. The insured person is considered to have been informed of the decision on the seventh day after the decision was sent.

A person who is dissatisfied with an additional benefit decision may also refer the matter to a court of law. The action must be brought within three years of the date on which the person dissatisfied with the benefit decision was informed of the fund's decision and the three-year time limit. The court is the local court of the registered office of the fund – that is, the District Court of Western Uusimaa. The action may also be examined in the district court in whose jurisdiction the claimant is domiciled or habitually resident.

EQUITY FUNDS

25 The fund has a reserve fund and a contingency fund.

The reserve fund must be increased annually by at least 20% of the surplus shown in the financial statements after deduction of the deficit shown on the balance sheet from previous financial periods. When the reserve fund is at least equal to the average insurance premium revenue for the financial period and the two previous financial periods, transfers to the reserve fund are no longer mandatory.

The reserve fund may only be reduced, in accordance with the decision of the fund meeting, to cover the deficit shown on the adopted balance sheet.

Notwithstanding the provisions of section 3, the Financial Supervisory Authority may, by means of application, grant the fund permission to reduce its reserve fund for specific reasons, but generally not below the full reserve fund amount.

26 The portion of the surplus that has not been transferred to the reserve fund must be transferred to the contingency fund. The contingency fund may be used for the following purposes:

1) As a primary means to cover any deficit shown in the financial statements

2) To increase the benefits determined in section 14 of the rules, at the discretion of the Board, in accordance with a plan confirmed by the Board for a maximum period of one year at a time.

3) For purposes referred to in section 17 of the rules.

TECHNICAL PROVISIONS

27 The technical provisions of the fund consist of a compensation liability equal to the compensation amounts and other amounts outstanding that arise from insurance events that have occurred. The compensation liability is calculated for the financial statements in accordance with the regulations of the Financial Supervisory Authority.

FINANCIAL STATEMENTS

28 The fund's financial period is the calendar year.

In accordance with Decree 1336/2002 of the Ministry of Social Affairs and Health and the regulations of the Financial Supervisory Authority, financial statements must be prepared for each financial period, including an income statement, balance sheet and the required notes. The financial statements must also include a Board of Directors' report.

The financial statements and the Board of Directors' report must be submitted to the auditors for audit no later than one month before the Representative Council Meeting.

29 The contingency fund is primarily used to cover any fund deficit.

The reserve fund is used for this purpose if the contingency fund is not sufficient to cover the deficit. The fund does not have an additional payment obligation under chapter 4, section 12 of the Public Insurance Funds Act.

AUDIT

30 The fund's auditor is selected for one calendar year at a time. The auditor can be a natural person or a firm of authorised public accountants. If the auditor is a natural person, a deputy must be selected for them. If the auditor is a firm of authorised public accountants, no deputy is selected. The auditor and their deputy must meet the requirements of the Auditing Act (1141/2015).

REPRESENTATIVE COUNCIL MEETING

31 The Representative Council Meeting exercises the highest power of decision-making in matters concerning the fund. The members of the Representative Council are elected for four calendar years at a time.

The Representative Council Meeting must be held in the fund's domicile. If the Board of Directors so separately decides, the meeting may also be attended by means of a telecommunications connection or other technical aid.

32 The members of the Representative Council are elected by the insured persons and the stakeholders from among themselves for a term of office in accordance with the election procedure annexed to these rules. However, at least 20 representatives are always elected to the Representative Council. Only insured persons can be candidates in an election, and only insured persons can serve as representatives or deputy representatives on the council. A member or deputy member of the Board of Directors cannot be elected to the Representative Council.

More detailed provisions concerning the election of the council are provided in the election procedure annexed to these rules.

Each representative of the insured persons has one vote at the Representative Council

Meeting. Together, the stakeholders represent a number of votes at the meeting that corresponds to the total number of votes of the insured persons' representatives present at the meeting.

The stakeholders' total number of votes at the meeting is divided between the stakeholders represented at the meeting in proportion to their insurance premiums over the previous financial period.

A member of the Representative Council cannot be represented at the meeting by way of proxy. The services of assistants must not be utilised at the meeting.

The Representative Council members and deputy members are paid a meeting fee, the amount of which is decided by the Representative Council Meeting.

33 The fund has one Representative Council Meeting per year.

At a Representative Council Meeting, to be held no later than April:

1) The financial statements and the auditor's report are presented

2) A decision is made on the adoption of the previous year's financial statements

3) A decision is made on discharging the Board members and the managing director of the fund from liability

4) A decision is made on using any surplus or covering any deficit

5) Decisions are made on other measures that may be necessary based on the previous year's operations and financial statements

6) Decisions are made on the fees to be paid to the members of the Representative Council, the Chair of the Board, the other members of the Board and the auditors

7) The necessary members and deputy members are elected to replace the members and deputy members whose term of office is ending

8) The auditors and the necessary deputy auditors are selected, and

9) Any other matters mentioned in the invitation to the meeting are discussed.

34 An extraordinary Representative Council Meeting must be held when the Board deems this necessary.

An extraordinary fund meeting must also be held if persons entitled to vote at a Representative Council Meeting who hold at least one-tenth of the total number of votes held by the persons entitled to vote so require in writing to address a matter specified

by them, or if the Financial Supervisory Authority or the fund's auditor so require in writing to address a matter specified by them.

An invitation to the meeting must be submitted within fourteen days of presenting such a requirement in accordance with section 2.

35 An invitation to a Representative Council Meeting must be submitted no earlier than four weeks and no later than one week before the meeting. If finalising a decision on a matter addressed at a Representative Council Meeting is postponed until a subsequent meeting, a separate invitation must be submitted if the subsequent meeting is held later than four weeks from the meeting where the decision was postponed.

Invitations to a Representative Council Meeting are submitted to the members of the Representative Council and stakeholders by post or email. Other notices from the fund are published on the fund's website.

36 The notice of the Representative Council Meeting must specify the time and place of the meeting and the matters to be discussed at the meeting. If financial statements are to be discussed at a Representative Council Meeting, the documents concerning the financial statements, or copies of such documents, must be made available for the insured persons to review at the fund's office for at least one week before the meeting. A similar procedure is required if a matter concerning amendments to the rules is to be discussed at a Representative Council Meeting. Such a review period must be announced in the invitation to the meeting and on the fund's website.

If amendments to the rules are to be discussed at a Representative Council Meeting, the main content of the amendments must be mentioned in the invitation to the meeting.

37 Representative Council Meetings are chaired by a person elected by the meeting for this purpose.

The decision of the Representative Council Meeting will be the opinion that has been supported by more than half of the votes cast, unless otherwise provided by law or by any other provision of these rules. In the event of a tie, the Chair's vote will be decisive.

In an election, the person who receives the highest number of votes is deemed to have been elected. In the event of a tie, the election is settled by lot.

A decision concerning amendments to the rules of the fund is valid only if it has been supported by those entitled to vote who hold at least two-thirds of the total number of

votes represented at the meeting. The same requirement applies to the fund going into liquidation and the reversal of liquidation in cases other than those required by the law, and to the approval of a merger agreement concerning the fund.

If the amendments to the rules directly concern a stakeholder's rights or obligations, the amendments
must also be approved by the stakeholder at a Representative Council Meeting or otherwise before they can be adopted. If the amendments concern multiple stakeholders, the amendments must be approved by at least two-thirds of all stakeholders at a Representative Council Meeting or otherwise. In addition, the number of votes cast by the stakeholders who approved the amendments must represent at least two-thirds of the total number of votes that the stakeholders would have held if all the stakeholders had been represented at the Representative Council Meeting.

38 Decisions on matters in which the regulations concerning invitations to meetings, or concerning making documents available for review, have not been followed in accordance with the law, or in accordance with these rules, must not be made without consent from the neglected parties. However, regardless of an invitation, a Representative Council Meeting is legal if all representatives are present. If a matter must be processed at a Representative Council Meeting in accordance with the law or these rules, the meeting is entitled to make a decision even if the matter is not mentioned in the invitation to the meeting. A Representative Council Meeting may also always decide to convene an extraordinary fund meeting to discuss a specific matter.

An insured person or a stakeholder has the right to have a specific matter discussed at a Representative Council Meeting if they so require in writing from the Board in good time, so that the matter can be included in the invitation to the meeting.

39 Minutes are kept at Representative Council Meetings, in which the following must be recorded: the persons present who are entitled to vote and their number of votes, the decisions made at the meeting and the results of any votes concerning decisions. The minutes must be checked and signed by the Chair and one of the persons entitled to vote at the meeting, who is elected for this purpose. The minutes must be numbered consecutively and stored in a reliable manner. The minutes must be made available for review by the insured persons and stakeholders at the fund office or otherwise no later than two weeks after the meeting.

BOARD OF DIRECTORS

40 The fund's Board of Directors consists of eight members, each of whom must have a personal deputy member.

The Board members are elected by the Representative Council Meeting. The insured persons elect four ordinary members of the Board of Directors and their deputy members. The stakeholders elect four Board members and their deputy members. A member or deputy member of the Representative Council, the managing director of the fund or a member of the staff of the fund cannot be a member or deputy member of the Board.

The Board is elected for four years at a time. The term of office begins at the end of the Representative Council Meeting during which the election was held. Each year, one Board member and their deputy member elected by the insured persons and one Board member and their deputy member elected by the stakeholders resign from the Board following this amendment to the rules. At first, the resigning members are selected by lot, and then in successive turns.

The Board members and deputy members are paid a meeting fee, the amount of which is decided by the Representative Council Meeting.

41 The Board represents the fund and is responsible for its administration and the appropriate organisation of its operations.

The duties of the Board specifically include the following:

1) Appointing and dismissing the managing director and the fund's medical specialist and determining the terms and conditions of their employment

2) Providing the managing director with the instructions and regulations necessary for the fund's day-to-day administration and other operations

3) Ensuring the proper organisation of the fund's accounting and asset management

4) Deciding on the investment of the fund's assets and on borrowing

5) Deciding on the provision of benefits unless the Board has authorised the managing director or an employee of the fund to do so

6) Convening a Representative Council Meeting and preparing matters to be discussed at the meeting and making a proposal, as part of the Board of Directors' report, concerning measures to be taken in respect of the surplus or deficit shown in the financial statements, and

7) Granting the right to sign on behalf of the fund.

42 The Board elects its Chair and Vice Chair from among its members annually. In

alternate years, one of these officials must be elected by the stakeholders and the other by the insured persons.

The Board is convened by the Chair, or by the Vice Chair if the Chair is prevented from doing so. The Chair must convene the Board of Directors if a Board member or the managing director so requests.

The Board has a quorum when the Chair or the Vice Chair and at least four other members or deputy members are present.

A decision of the Board is made when a proposal is supported by more than half of those present. In the event of a tie, the Chair's vote will be decisive.

A Board member or the managing director must not participate in discussing a matter concerning the relationship between them and the fund or their private interests in any other way.

43 Minutes must be kept of Board meetings, and the minutes must be signed by the Chair of the meeting and the author of the minutes. The minutes are checked by two members selected by the Board for this particular purpose at each meeting. The Board members and the managing director are entitled to have their differing opinion recorded in the minutes. The minutes must be numbered consecutively and stored in a reliable manner.

The following must be recorded in the minutes:

1) The date of the meeting, its start and end times, and the venue
2) The Board members and other persons present at the meeting
3) The matters discussed, decisions made and elections held at the meeting, as well as differing opinions, and
4) Disqualification from decision-making and other matters deemed necessary.

MANAGING DIRECTOR AND MEDICAL SPECIALIST

44 The managing director is responsible for managing the fund in accordance with the instructions and orders issued by the Board of Directors. The managing director must ensure that the fund's accounting complies with the law and that its asset management is organised in a reliable manner.

The managing director has the right to represent the fund in matters falling within their duties under section 13 of the Act on Pension Foundations and Pension Funds.

The fund must have a medical specialist, who is responsible for serving as a medical expert for the fund.

SIGNATURE ON BEHALF OF THE FUND

45 Documents can be signed on behalf of the fund by a Board member and the managing director and or an employee of the fund authorised by the Board, two at a time.

INVESTMENT OF ASSETS AND BORROWING

46 The fund must invest its assets securely and profitably, ensuring liquidity. The fund's assets must not be used for purposes which are foreign to its operations.

The fund must adjust its operations so that it is possible to operate without borrowing.

However, the fund may temporarily take out short-term loans to maintain liquidity. The fund may not provide a guarantee for a loan.

AMENDMENT OF STAKEHOLDER DUTIES

47 If a stakeholder wishes to change their obligations under these rules, they must notify the fund of this in writing no later than 12 months before the amendment enters into force.

After having received notification from the stakeholder, the fund must take immediate action to implement the necessary amendments to the rules. This procedure also applies when a stakeholder has submitted
a notice of resignation.

MERGER AND DIVISION

48 The fund may merge and be divided. In the event of a merger or division and the related measures, compliance with chapter 7 of the Public Insurance Funds Act is required.

STATUTORY LIQUIDATION AND DISSOLUTION

49 The liquidation and dissolution of the insurance fund and the related measures must be

carried out in accordance with chapter 9 of the Public Insurance Funds Act.

The fund must be put into liquidation and dissolved:

1) If the number of members of the fund has not met the minimum requirement provided in section 3 of the rules over the last two calendar years, and it cannot be considered likely that the number of members will increase and meet the requirement within the next four months

2) If the financial statements of the fund show a deficit and the deficit is not covered during the next two financial periods

3) If the fund does not meet the criteria for calculating technical provisions or the requirements for covering technical provisions and separating the coverage

4) If the rules specifically so provide

5) If the Financial Supervisory Authority has ordered the liquidation of the fund

50 If the fund is dissolved, the remaining assets will be distributed to those who were insured by the fund at the beginning of its liquidation. The funds will be distributed in proportion to the premiums paid by them over the 36 months immediately preceding the beginning of the liquidation. If the amount to be distributed is insignificant, the Representative Council Meeting may, with a majority of two-thirds of the votes, decide that the assets be used for a purpose similar to the fund's operations or for the common good.

ELECTION PROCEDURE OF THE ENERKEMI INSURANCE FUND

1
This election procedure is followed when electing representatives of the insured persons onto the Representative Council serving as the fund meeting.

Each stakeholder elects its representative in accordance with the stakeholder company's own selection policy. A stakeholder may elect a personal deputy member for an ordinary member. The stakeholder's selections must be submitted to the fund office by the end of the November preceding the beginning of the Representative Council's term of office.

The Board of Directors is responsible for carrying out the election. The managing director and the employees of the fund are responsible for organising the election.

2
The election of the Representative Council is carried out during the November preceding the beginning of the term of office of the Representative Council to be elected.

3
Insured persons who were insured by the fund on 1 September in the election year can participate in the election of the Representative Council.

Insured persons can be elected onto the Representative Council. Candidates must register at the fund office by 15 October.

4
For the purposes of carrying out the election, the insured persons are divided into electoral districts by stakeholder.

The number of members of the Representative Council elected by the insured persons is proportional to the number of members of the electoral district, so that no more than one member of the Representative Council may be elected for every 200 insured persons. The numbers of insured persons in the electoral districts are determined in accordance with the insurance relationships in force on 1 September of the electoral year. The number of members of the Representative Council to be elected from an electoral district is indicated in the election notice.

If an electoral district has fewer candidates than it has seats on the Representative Council, or if it has as many candidates as it has seats on the Representative Council, the candidates will be selected without an election.

5
Information about the election is provided during September on the fund's website and in accordance with each company's announcement policy.
The candidate lists are published on the fund's website by the end

of October.

6.
The election is carried out as a postal vote or an electronic election. The election can be conducted electronically if it is possible to do so while maintaining confidentiality and anonymity.

7
Representatives are elected from each district based on their number of votes so that representatives are selected in proportion to the total number of insured persons in accordance with section 32 of the rules. Based on their number of votes, the representatives are selected first, and their personal deputies are selected thereafter. As many of the deputy representatives' seats are filled as the number of candidates after the election of the actual members allows.

In the event of a tie, the election is settled by lot.

8
The seat of a member of the Representative Council of the insured persons will become vacant during the term of office of the Representative Council if the person elected onto the Representative Council leaves the employment of the group from which they were elected onto the Representative Council. The deputy member becomes an ordinary member of the Representative Council for the remainder of the term of office. If no deputy member is available, the Representative Council will be supplemented for the remainder of the term of office on the basis of the results of the previous elections in the order indicated by the number of votes, in accordance with the selection principle set out in section 7.

If the ordinary representative elected by a stakeholder leaves the employment of the stakeholder during the term of office of the Representative Council, the deputy member becomes an ordinary member for the remainder of the term of office. If no deputy member has been elected or the deputy is not available, the stakeholder can elect a new representative for the remainder of the term of office.

9
If the dates mentioned in this election procedure coincide with a weekend or a public holiday, the measure in question can be carried out on the next business day.

10
The Board is responsible for announcing the result of the election before the beginning of the next financial period. Those selected onto the Representative Council will be informed personally, and the composition of the elected Representative Council will be published on the fund's website.

11

Amendments to this election procedure must be confirmed at a Representative Council Meeting serving as a fund meeting.