INSURANCE PRODUCT INFORMATION DOCUMENT
AND GENERAL TERMS AND CONDITIONS OF THE SUPPLEMENTARY GROUP INSURANCE WITH PHARMACY BENEFITS CARD

Insurance Product Information Document

SUPPLEMENTARY GROUP INSURANCE WITH PHARMACY BENEFITS CARD

Terms and Conditions Code: APGP56

Document version dated 22 November 2025

This document contains information about the insurance product. Full details of the insurance are provided in other documents, in particular in the General Terms and Conditions of the Supplementary Group Insurance with Pharmacy Benefits Card, Terms and Conditions Code: APGP56 (the GTC).
Before deciding whether to enter into the insurance contract, please read the GTC carefully. Definitions used in the GTC may differ from their commonly accepted meaning; therefore, please pay particular attention to them.
The conclusion of the contract is voluntary.

THIS DOCUMENT:

- is provided for information purposes only;
- does not form part of the insurance contract (the Contract);
- does not constitute an offer within the meaning of Article 66 of the Polish Civil Code;
- should not be relied upon as the sole basis for making a decision to enter into the Contract.

SUBJECT MATTER AND SCOPE OF COVER

We insure the health of the Insured Person.
The scope of the supplementary insurance covers the Insured Person's hospitalisation due to illness or an accident occurring during the cover period, provided that we have paid a benefit under the supplementary group hospital treatment insurance for the Insured Person.

PRODUCT FEATURES – THE MAIN FEATURES OF OUR INSURANCE

If you are hospitalised, we will issue you with a Pharmacy Benefits Card, which entitles you to collect pharmacy products up to the value of 100% of the sum insured applicable on the date your hospital stay commenced.
During each consecutive 12-month period between policy anniversaries, you may receive a Pharmacy Benefits Card in respect of a maximum of three hospital stays commenced during that period, provided that we have paid a benefit under the supplementary group hospital treatment insurance for the Insured Person. This means that you may receive a maximum of three Pharmacy Benefits Cards during any such period.
If you are transferred between one or more hospitals without interruption, we will treat this as a single hospital stay.

The supplementary insurance may be taken out either at the same time as the principal insurance policy – PZU Na Życie Plus Group Insurance – or during its term, provided that the supplementary group hospital treatment insurance for the Insured Person is entered into simultaneously or is already in force with the Policyholder.

ELIGIBILITY TO ENTER INTO THE CONTRACT AND PERSONS COVERED

The supplementary insurance contract is entered into by the Policyholder, who is responsible for paying the insurance premiums.
The supplementary insurance is available to Insured Persons who have joined both the principal insurance policy and the supplementary group hospital treatment insurance for the Insured Person.

DURATION OF THE CONTRACT

The Policyholder may enter into the supplementary insurance contract for a fixed term. The duration of the supplementary insurance is confirmed in the policy. If the supplementary insurance is taken out between policy anniversaries, our insurance cover will remain in force until the next policy anniversary.

TERRITORIAL SCOPE OF COVER

Our insurance cover applies to hospital stays anywhere in the world. Pharmacy products may be collected using a Pharmacy Benefits Card issued following a hospital stay only from a pharmacy operating in Poland in accordance with the Pharmaceutical Law.

PAYMENT OF PREMIUMS

Premiums are paid by the Policyholder on a monthly basis together with the premium for the principal insurance policy.

COMMENCEMENT AND TERMINATION OF INSURANCE COVER

Cover under the supplementary insurance commences in accordance with the terms set out in the principal insurance policy. Cover under the supplementary insurance will commence only if cover under both the principal insurance policy and the supplementary group hospital treatment insurance for the Insured Person is in force.

Insurance cover under the supplementary insurance shall terminate:

- on the date cover under the principal insurance policy or the supplementary group hospital treatment insurance for the Insured Person terminates;
- on the date we receive the Policyholder's notice of withdrawal from the supplementary insurance;
- on the expiry date of the supplementary insurance cover, where it is not renewed;
- on the last day of the month in which you opt out of the supplementary insurance;
- at the end of the month during which the supplementary insurance remains in force on its existing terms and conditions, if you have not provided the required consent to a change in the supplementary insurance;
- on the date the notice period for termination of the supplementary insurance expires;
- on the date the supplementary insurance contract is terminated.

MAIN EXCLUSIONS AND LIMITATIONS OF INSURANCE COVER

We will not provide a benefit in the event of:

- a fourth or subsequent hospital stay during any annual period of the insurance contract;
- the absence of our insurance cover during the hospital stay;
- failure to provide the documents necessary to assess the validity of the claim.

In addition, we shall not be liable where the event concerned falls outside the scope of cover, does not meet the definition specified in the Contract, where our liability has ceased, or in any other circumstances specified in the GTC.

TERMINATION OF THE CONTRACT

The Policyholder may withdraw from the supplementary insurance contract within:

- 7 days of entering into the contract, if the Policyholder is a business undertaking;
- 30 days of entering into the contract, if the Policyholder is not a business undertaking.

After this period, the Policyholder may terminate the contract by giving written notice.
The Policyholder may elect not to renew the supplementary insurance by submitting a written declaration of non-renewal no later than 30 days before the expiry of the insurance period.

INSURANCE DISTRIBUTOR'S REMUNERATION

Under the proposed contract, the insurance distributor receives commission-based remuneration.

COMPLAINTS, GRIEVANCES AND APPEALS

1. A complaint, grievance or appeal may be submitted at any of our customer service offices.
2. A complaint, grievance or appeal may be made:

1) in writing – in person or by post within the meaning of the Postal Law Act, for example by writing to: PZU Życie SA ul. Postępu 18A, 02-676 Warsaw (correspondence address only), or by submitting correspondence through a postal or delivery service provider operating within the European Union;
2) in writing – by sending it to the electronic delivery address of PZU Życie SA within the meaning of the Electronic Deliveries Act: AE:PL-50066-37983-FBWRA-37, as registered in the electronic address database referred to in the Act on Electronic Delivery;

3) verbally – by telephone, for example by calling our helpline on 801 102 102, or in person at one of our offices, in which case the submission will be recorded in a written report;
4) electronically – by sending an email to reklamacje@pzu.pl or by completing the online form available at pzu.pl or www.moje.pzu.pl.

3. We will respond to any complaint or grievance as soon as possible and no later than 30 days from the date of receipt. In particularly complex cases, where it is not possible to provide a response within 30 days, we will inform you:
1) of the reasons for the delay;
of the circumstances that still need to be established in order to resolve the matter;
2) of the revised deadline for our response, which shall not exceed 60 days from the date on which we received the complaint, grievance or appeal.

4. Responses to complaints, grievances or appeals will be provided to the person who submitted them:
1) where the customer is a natural person, in writing; however, the response may be provided by electronic mail solely at the customer's request;
2) where the customer is an entity other than that referred to in item 1, in writing or by means of another durable medium.

5. If, following the investigation of the complaint:
1) we have not upheld the claims submitted; or
2) we have upheld the claims but have failed to carry out, within the timeframe specified in our response, the actions we undertook to perform,
– the individual who submitted the complaint may refer the matter to the Financial Ombudsman by submitting an application.

6. Complaints, grievances and appeals are considered by the organisational units responsible for the subject matter of the case.

7. Further information regarding complaints can be found in the Act on the Handling of Complaints by Financial Market Entities, the Financial Ombudsman and the Financial Education Fund, as well as in the Insurance Distribution Act.

8. We provide for the possibility of resolving disputes through out-of-court dispute resolution procedures.

9. For the purposes of the Act on Out-of-Court Consumer Dispute Resolution, the entity authorised to conduct out-of-court dispute resolution proceedings in relation to PZU Życie SA is the Financial Ombudsman. Financial Ombudsman's website: rf.gov.pl.

10. Where the Insured Person, the Policyholder, the Beneficiary or any entitled person is a consumer, they may also seek assistance from their municipal or district Consumer Ombudsman.

11. The language used by us in our dealings with consumers is Polish.

12. PZU Życie SA is supervised by the Polish Financial Supervision Authority (KNF).

Further information about the insurance is available:

WWW **on pzu.pl**

or by calling our helpline on 801 102 102
(charge according to the operator's tariff)

The table identifies the provisions of the General Terms and Conditions of the Supplementary Group Insurance with Pharmacy Benefits Card, Terms and Conditions Code APGP56 (the GTC), which set out the principal terms of the insurance contract.
This information forms part of the GTC and is provided pursuant to statutory requirements (Article 17(1) of the Insurance and Reinsurance Activity Act).

No.	Type of information	Clause reference
1.	Conditions for benefit payment	Clauses 1–2 Clauses 4–7 Clauses 8–9 Clauses 31–33 Clause 34
2.	Limitations and exclusions of the insurer's liability entitling it to refuse payment of benefits or to reduce the amount payable	Clauses 1–2 Clauses 28–29 Clause 30 Clause 34

GENERAL TERMS AND CONDITIONS OF THE SUPPLEMENTARY GROUP INSURANCE WITH PHARMACY BENEFITS CARD

GTC Code: APGP56

The Management Board of PZU Życie SA adopted these General Terms and Conditions of the Supplementary Group Insurance with Pharmacy Benefits Card by Resolution No. UZ/165/2025 dated 14 October 2025 (hereinafter referred to as the GTC).

These GTC come into force on 22 November 2025 and apply to insurance contracts concluded from 1 December 2025 onwards.

Before entering into the insurance contract, the Policyholder should carefully review the GTC and provide a copy of the GTC to each person wishing to join the insurance scheme.

Before joining the insurance, please read carefully the GTC provided to you by the Policyholder.

GLOSSARY
– what the terms used in these GTC mean

1. In these GTC, we use the following terms:
   1) **Pharmacy** – any publicly accessible pharmacy or pharmacy outlet operating in Poland in accordance with the Pharmaceutical Law Act;
   2) **Supplementary Group Hospital Treatment Insurance for the Insured Person** – the supplementary hospital treatment insurance designated by PZU Życie SA in the insurance contract;
   3) **Pharmacy Benefits Card** – a card entitling the holder to collect pharmacy products. The rules governing its use are set out in the Pharmacy Benefits Card Regulations;
   4) **Cover Period** – the period during which we are liable to the Insured Person under the supplementary insurance;
   5) **Pharmacy Products / Products** – products offered and available through a pharmacy;
   6) **Service Provider** – an entity that has entered into a cooperation agreement with us in relation to Pharmacy Benefits Cards. Such cooperation consists of organising the collection of products from pharmacies using Pharmacy Benefits Cards;
   7) **Supplementary Insurance** – the insurance contract to which these GTC apply;
   8) **Principal Insurance** – the PZU Na Życie Plus Group Insurance contract under which the Policyholder may take out the Supplementary Insurance.
2. Other terms used in these GTC are defined in the General Terms and Conditions of the Principal Insurance and the Supplementary Group Hospital Treatment Insurance for the Insured Person. Such terms shall have the same meaning when used in these GTC.

SUBJECT MATTER OF INSURANCE
– what is insured

3. We insure your health.

SCOPE OF INSURANCE AND BENEFITS UNDER THE CONTRACT
– when you may receive a Pharmacy Benefits Card

4. The Supplementary Insurance covers your hospitalisation due to illness or an accident occurring during the cover period, provided that we have paid a benefit under the Supplementary Group Hospital Treatment Insurance for the Insured Person.
5. If you are hospitalised, we will issue you with a Pharmacy Benefits Card, which entitles you to collect pharmacy products up to the value of 100% of the sum insured applicable on the date your hospital stay commenced, subject to the provisions of the following clause.
6. During each consecutive 12-month period between policy anniversaries, you may receive a Pharmacy Benefits Card in respect of a maximum of three hospital stays commenced during that period, provided that we have paid a benefit under the supplementary group hospital treatment insurance for the Insured Person. This means that you may receive a maximum of three Pharmacy Benefits Cards during any such period.
7. If you are transferred between one or more hospitals without interruption, we will treat this as a single hospital stay. The

continuity requirement shall be deemed satisfied where you are admitted to two or more hospital wards on consecutive days, regardless of the time of discharge from one ward or admission to another.

SUM INSURED

– – definition and amount

8. The Sum Insured is the amount used as the basis for calculating the value of the benefit.
9. The amount of the Sum Insured is specified in the policy and in the individual certificate of insurance.

PREMIUM

– – determination and payment of the premium

10. The premium for the Supplementary Insurance:
    1) is fixed, although it may be amended by agreement between the parties;
    2) depends on:
        a) the Sum Insured;
        b) the number of persons joining the insurance, their age and gender profile, and the nature of the work they perform.
11. The amount of the premium for the Supplementary Insurance is specified in the application for insurance and in the policy.
12. The Policyholder pays premiums for the Supplementary Insurance on a monthly basis together with the premium for the Principal Insurance.

TAKING OUT AND JOINING THE SUPPLEMENTARY INSURANCE

– how you become insured

13. The Supplementary Insurance may be taken out either at the same time as the Principal Insurance or during its term, provided that the Supplementary Group Hospital Treatment Insurance for the Insured Person is entered into simultaneously or is already in force with the Policyholder.
14. The supplementary insurance is available to Insured Persons who have joined both the principal insurance policy and the supplementary group hospital treatment insurance for the Insured Person.

DURATION OF THE SUPPLEMENTARY INSURANCE

– the period for which the Supplementary Insurance is taken out

15. The Policyholder may enter into the supplementary insurance contract for a fixed term. The duration of the supplementary insurance is confirmed in the policy. If the supplementary insurance is taken out between policy anniversaries, our insurance cover will remain in force until the next policy anniversary.

RENEWAL OF THE SUPPLEMENTARY INSURANCE

– the rules governing renewal of the Supplementary Insurance

16. Unless either party decides otherwise and provided that both the Principal Insurance and the Supplementary Group Hospital Treatment Insurance for the Insured Person remain in force, the Supplementary Insurance shall be automatically renewed for a further policy year on the same terms and conditions. In such circumstances, you, as the Insured Person, are not required to submit a new application to join the insurance.
17. Either party may elect not to renew the Supplementary Insurance by giving written notice to the other party. Such notice must be given no later than 30 days before the expiry of the Supplementary Insurance.

WITHDRAWAL FROM THE SUPPLEMENTARY INSURANCE

– the circumstances in which the Policyholder may withdraw from the Supplementary Insurance

18. Withdrawal from the Supplementary Insurance shall be governed by the rules set out in the Principal Insurance.
19. If the Policyholder withdraws from the Principal Insurance, this shall automatically result in withdrawal from the Supplementary Insurance.
20. If the Policyholder withdraws from the Supplementary Insurance, this shall not result in withdrawal from the Principal Insurance.
21. If the Policyholder withdraws from the Supplementary Group Hospital Treatment Insurance for the Insured Person, this shall automatically result in withdrawal from the Supplementary Insurance.
22. If the Policyholder withdraws from the Supplementary Insurance, this shall not result in withdrawal from the Supplementary Group Hospital Treatment Insurance for the Insured Person.

TERMINATION OF THE SUPPLEMENTARY INSURANCE
– how the Policyholder may terminate the Supplementary Insurance

23. Termination of the Supplementary Insurance shall be governed by the rules set out in the Principal Insurance.
24. If the Policyholder terminates the Principal Insurance, this shall automatically result in termination of the Supplementary Insurance.

25. If the Policyholder terminates the Supplementary Insurance, this shall not result in termination of the Principal Insurance.
26. If the Policyholder terminates the Supplementary Group Hospital Treatment Insurance for the Insured Person, this shall automatically result in termination of the Supplementary Insurance.
27. If the Policyholder terminates the Supplementary Insurance, this shall not result in termination of the Supplementary Group Hospital Treatment Insurance for the Insured Person.

COMMENCEMENT OF COVER
– when your insurance cover begins

28. Cover under the supplementary insurance commences in accordance with the terms set out in the principal insurance policy.
29. Cover under the supplementary insurance will commence only if cover under both the principal insurance policy and the supplementary group hospital treatment insurance for the Insured Person is in force.

TERMINATION OF COVER
– when the Supplementary Insurance ends

30. Insurance cover under the supplementary insurance shall terminate:
1) on the date cover under the Principal Insurance or the Supplementary Group Hospital Treatment Insurance for the Insured Person terminates;
2) on the date we receive the Policyholder's notice of withdrawal from the Supplementary Insurance;
3) on the expiry date of the Supplementary Insurance cover, where it is not renewed;
4) on the last day of the month in which you opt out of the Supplementary Insurance;
5) at the end of the month during which the Supplementary Insurance remains in force on its existing terms and conditions, where you have not provided the required consent to a change in the Supplementary Insurance;
6) on the date the notice period for termination of the Supplementary Insurance expires;
7) on the date the supplementary insurance contract is terminated.

ENTITLEMENT TO A PHARMACY BENEFITS CARD FOLLOWING HOSPITALISATION
– who is entitled to receive a Pharmacy Benefits Card and when it is issued

31. You are entitled to receive a Pharmacy Benefits Card.
32. A claim submitted for payment of a benefit under the Supplementary Group Hospital Treatment Insurance for the Insured Person shall also constitute an application for the issue of a Pharmacy Benefits Card under this Supplementary Insurance, subject to the provisions of the following clause.
33. We shall pay the benefit as a single lump-sum payment in the full amount due only in the following circumstances:
1) termination of the cooperation agreement with the Service Provider in respect of Pharmacy Benefits Cards;
2) inability to collect products from a pharmacy due to circumstances attributable to the service provider, including its liquidation or insolvency.

FINAL PROVISIONS
– other important information

34. In matters not governed by the Supplementary Insurance, the General Terms and Conditions of the Principal Insurance, the provisions of the Polish Civil Code, the Insurance and Reinsurance Activity Act, and any other applicable laws and regulations shall apply.

PHARMACY BENEFITS CARD REGULATIONS

Appendix to the General Terms and Conditions of the Supplementary Group Insurance with Pharmacy Benefits Card.

These Regulations set out the rules governing:
- activation of the Pharmacy Benefits Card;
- use of the Pharmacy Benefits Card.

GLOSSARY
– – what the terms used in these Regulations mean

1. In these Pharmacy Benefits Card Regulations, the following terms shall have the meanings set out below:
   1) **Expiry Date** – the last day of the month falling three years after the end of the month in which the decision to grant you a Pharmacy Benefits Card was issued;
   2) **Proof of Purchase** – evidence confirming the purchase of products from a pharmacy during the validity period of the Pharmacy Benefits Card (for example, a receipt or invoice);
   3) **Replacement Pharmacy Benefits Card** – a card issued in place of a blocked Pharmacy Benefits Card. It has the same characteristics
   as the blocked Pharmacy Benefits Card, including the same expiry date, and its available limit is reduced by the value of products already collected using either the original Pharmacy Benefits Card or the Replacement Pharmacy Benefits Card;
   4) **Limit** – the value of products which, under the insurance, you are entitled to collect from a pharmacy;
   5) **Collection of Products from a Pharmacy Without Using a Pharmacy Benefits Card** – the purchase of products from

PHARMACY BENEFITS CARD
– – key information

2. The Pharmacy Benefits Card is used to collect products from a pharmacy.
3. Information regarding the following is available on our website at pzu.pl, via our helpline and at PZU branches:
   1) the current list of Pharmacies that accept the Pharmacy Benefits Card;
   2) the procedures for collecting Products from a Pharmacy both with and without the use of a Pharmacy Benefits Card.
4. The Pharmacy Benefits Card contains:
   1) an identification number;
   2) a barcode;
   3) an expiry date;
   4) a limit.
5. The Pharmacy Benefits Card will be activated once you submit an instruction requesting its activation. Activation will be carried out on the basis of your personal data and the Pharmacy Benefits Card identification number. The Pharmacy Benefits Card will be activated no later than the following day. Instructions on how to activate the Pharmacy Benefits Card will be included in the correspondence accompanying the Pharmacy Benefits Card.
6. The Pharmacy Benefits Card shall cease to be valid:
   1) on the date products are collected up to the full value of the limit;
   2) on its expiry date;
   3) on the date it is blocked, in accordance with Clauses 16 and 17.

RULES FOR USING THE PHARMACY BENEFITS CARD
– – how to use it

7. The Pharmacy Benefits Card must be activated before products can be collected from a pharmacy.
8. To collect products using the Pharmacy Benefits Card, present your active Pharmacy Benefits Card at a pharmacy that accepts Pharmacy Benefits Cards.
9. To obtain reimbursement for products purchased from a pharmacy without using the Pharmacy Benefits Card, you must notify us and provide proof of purchase together with evidence that you hold an active Pharmacy Benefits Card. We will reimburse the cost of such products within 21 days of receiving your notification
   and confirmation that you hold an active Pharmacy Benefits Card, up to the amount of the remaining limit available on the Pharmacy Benefits Card.
10. The Pharmacy Benefits Card cannot be exchanged for cash.
11. Each time the Pharmacy Benefits Card is used, the available limit is reduced accordingly. Information regarding the remaining available limit may be obtained from any pharmacy that accepts the Pharmacy Benefits Card or through our helpline.
12. If the value of your purchases exceeds the available limit on the Pharmacy Benefits Card, you must pay the balance from your own funds.
13. Products collected using the Pharmacy Benefits Card cannot be returned, subject to Clauses 22 and 23.
14. We will pay you the cash equivalent of any unused limit remaining on the Pharmacy Benefits Card in the event of the liquidation or

insolvency of the service provider.

15. If your Pharmacy Benefits Card is lost, destroyed or damaged, you must notify our helpline immediately.

BLOCKING OF THE PHARMACY BENEFITS CARD

– procedure in such circumstances

16. We will block the Pharmacy Benefits Card if:
1) our helpline receives information that you have not received the Pharmacy Benefits Card within 30 days of dispatch for reasons beyond our control;
2) you notify our helpline that the Pharmacy Benefits Card has been lost, destroyed or damaged in a manner that prevents its use.

17. The Pharmacy Benefits Card will be blocked no later than the day following receipt by our helpline of the information referred to in Clause 16.

18. Blocking of the Pharmacy Benefits Card is irreversible.

19. We shall not be liable for any unauthorised use of the Pharmacy Benefits Card occurring:
1) before notification of the loss, destruction or damage of the Pharmacy Benefits Card;
2) as a result of the Pharmacy Benefits Card being made available to another person.

REPLACEMENT PHARMACY BENEFITS CARD

– when it is issued

20. A Replacement Pharmacy Card will be issued following the blocking of the original Pharmacy Benefits Card. The Replacement Pharmacy Benefits Card will have the remaining limit available at the time the original Pharmacy Benefits Card was blocked.

21. The Replacement Pharmacy Benefits Card will be issued with a new identification number and will initially be inactive. The Replacement Pharmacy Benefits Card must be activated in accordance with Clause 5.

COMPLAINTS RELATING TO THE USE OF THE PHARMACY BENEFITS CARD

– how to submit a complaint

22. Complaints relating to the use of the Pharmacy Benefits Card may be submitted through our helpline.

23. Complaints concerning products purchased using the Pharmacy Benefits Card due to defects in quality or incorrect dispensing shall be handled by the pharmacy in accordance with applicable law, in particular the provisions of pharmaceutical legislation.

24. Where a product is returned as a result of a complaint referred to in Clause 23, the pharmacy shall refund the amount corresponding to the value of the returned product.

25. In addition, the submission and handling of complaints and grievances shall be governed by the rules set out in the Principal Insurance.

FINAL PROVISIONS

– other important information

26. In matters not regulated by these Regulations, the General Terms and Conditions of Insurance, the provisions of the Polish Civil Code, the Insurance and Reinsurance Activity Act, and any other applicable laws and regulations shall apply.