COMPLAINT MANAGEMENT POLICY

To continue providing its customers with top-quality services, Blue Cross follows a complaint management policy.

OBJECTIVE

The goal of this policy is to ensure that all consumer complaints about a product or service are processed fairly and diligently.

PROCESS AND STEPS FOR FILING A COMPLAINT

STEP 1: *Ask for an explanation*

As a first step, we suggest that you contact the Customer Service Department and **ask for an explanation** regarding the product or service you found unsatisfactory.

Customer Service Department

- Travel insurance : 1 800 361-5706
- Health Insurance : 1 844 904-8353

STEP 2 : *If you're not satisfied with the explanation, you can request a review*

In the event the explanation provided by the Customer Service Department is not satisfactory, you may ask the Customer Service Department or the person directly in charge of the department involved with your inquiry to request a **review of your file**.

STEP 3: *File a formal complaint*

If you are still dissatisfied with the decision made or with how your file was processed, you can **file a formal complaint** by writing the Dispute Resolution Officer or by filling out our complaint form:

Dispute Resolution Officer
Quebec Blue Cross
550, Sherbrooke West street, Suite B-9
Montreal, (Quebec) H3A 3S3
Courriel : plaintes@qc.croixbleue.ca

Please note that a **formal complaint** is the expression of one of the following elements, which persists after being considered and examined at the operational level responsible for making a decision:

- A reproach against the company;
- Identification of real or potential harm that you have or could have sustained;
- A request for remedial action.

If you do not use our complaint form, it is important to provide your contact information and describe the reason for your complaint, the steps you have already taken, and the responses you have received. Please indicate your arguments and the solution you are seeking.

Upon receipt of a **formal complaint** from a customer, the Dispute Resolution Officer will issue an acknowledgement of receipt with five (5) days of receiving the complaint. The acknowledgement of receipt will include:

- A description of the complaint received;
- The expected processing time for the complaint;
- A notice indicating alternative dispute-resolution mechanisms available to you in the event you remain unsatisfied with how your complaint was processed or the result of the review;
- The procedure for requesting that your file be forwarded to Autorité des marchés financiers or the OmbudService for Life & Health Insurance.

The Dispute Resolution Officer will ensure that the company's decision, including the reasons for it, is sent to you in writing.

STEP 4 : Transfer the complaint

If after these steps you are still not satisfied with the process or response, you may ask our Dispute Resolution Officer to forward a copy of your file to: :

- Quebec residents only : Autorité des marchés financiers au Québec (www.lautorite.qc.ca/grand-public/assistance-plainte-et-indemnisation/porter-plainte-aupres-dun-representant-ou-dune-entreprise/) ;
- All clients: OmbudService for Life & Health Insurance (www.oapcanada.ca)

Please note that you can request the transfer of your file to the Autorité des marches financiers at any time but only after receiving our final answer or if more than 90 days have passed since your complaint was filed in the case of the OmbudService for Life & Health Insurance.

CREATION AND MAINTENANCE OF A REGISTER

A complaint register is created for applying the policy. Complaint information is recorded and updated by the person responsible for handling complaints.

REPORT SUBMITTED TO THE REGULATORS

The Dispute Resolution Officer periodically reports complaints to the relevant provincial regulators.

EFFECTIVE DATE

This policy was adopted in January 2006. This policy was amended in December 2016, September 2018 and July 2019.

This policy will be revised every 3 years or more quickly if the situation requires it.