Insurance Strategy

TelstraSuper Pty Ltd

Version #	Date of Policy	Changes made	Updated by
1.0	1 July 2013	Insurance Strategy introduced	Legal
2.0	1 July 2014	Insurance Strategy updated	Insurance Operations Manager
3.0	August 2015	Insurance Strategy updated with greater detail responding to APRA insurance findings, to reflect change from a Self-Insurance to a Self-Insurance Run-Off Reserve and reduce review frequency from annual to biennial	Executive GM Operations and Legal
4.0	August 2016	Insurance Strategy updated to provide greater details responding to KPMG's insurance comprehensive review findings and periodic review.	Executive GM Operations and Risk & Compliance
5.0	August 2017	Strategy updated primarily to include the new insurance rates and 3-year premium rate guarantee from 1 July 2017.	Insurance Operations Manager
6.0	December 2018	Amendments as result of Insurance Code and other minor amendments	Executive GM Operations
7.0	December 2020	Amendments to reflect new insurance arrangements and rates with MLC, legislative changes, and other minor amendments	Executive GM, Operations
8.0	June 2021	Amendment to reflect that the Executive GM, Operations, and the Product Manager's attendance at monthly insurer meetings is on an 'as needed' basis	Manager, Insurance & Claims
9.0	July 2022	Strategy updated to reflect changes in SPS250 and SPG250 effective 1 July 2022 and other minor general amendments	Head of Insurance & Claims
10.0	July 2023	Strategy updated to reflect changes in insurance rates from 1 July 2023 to 30 June 2026, and other minor general amendments	Head of Insurance & Claims

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Definitions

AAL	Automatic Acceptance Limit
APRA	Australian Prudential Regulation Authority
CAC	Claims Assessment Committee
CMF	Conflicts Management Framework
Code	Insurance in Super Voluntary Code of Practice
DB	Defined Benefit
FSC	Financial Services Council
Fund or TelstraSuper	the Telstra Superannuation Scheme (used interchangeably in this document with 'Trustee')
IC	Insurance Covenants
ICA	Insurance Contracts Act 1984
IMF	Insurance Management Framework
IP	Income Protection
IS	Insurance Strategy
MEC	Member Experience Committee
PMIF	Putting Member's Interests' First
PYS	Protecting Your Super
RBA	Reserve Bank of Australia
RSE	Registrable Superannuation Entity (used interchangeably in this document with 'Trustee
SIS Act	Superannuation Industry (Supervision) Act 1993
SIS Regulations	Superannuation Industry (Supervision) Regulations 1994
SLA	Service Level Agreement
SPG 250	APRA Prudential Practice Guide SPG 250 – Insurance in Superannuation
SPS 250	APRA Prudential Standard SPS 250 Insurance in Superannuation
TPD	Total and Permanent Disablement
Trustee	Telstra Super Pty Ltd

1. Overview

In accordance with the specific components and detail in Prudential Standard SPS 250 – Insurance in Superannuation, TelstraSuper Pty Ltd, a Registrable Superannuation Entity (**RSE**) that holds a RSE licence granted under section 29D of the *Superannuation (Industry) Supervision* Act 1993 (SIS Act), has developed an Insurance Strategy (IS) which complies with the Insurance Covenants in section 52(7) of the SIS Act.

The insurance strategy is a key component of the insurance management framework (IMF) and addresses all the matters set out in the SIS Act including the type and level of insurance that will be offered to beneficiaries. The IS strategy involves ongoing analysis of membership cohorts to form the basis for assessing the insurance needs and the effect of insurance costs on the retirement income of the beneficiaries.

The IS aims to ensure that insurance cover is fit for purpose, meets the needs of the beneficiaries and provides value for money and at a cost that does not inappropriately erode retirement benefits aligned to the Protecting Your Super and Putting Members' Interests First legislation.

The Trustee will only consider insurance policies that satisfy the conditions of release in the SIS Regulations and comply with SPS 250, where the insured benefits are made available to beneficiaries via insurance acquired from a Life Company registered under section 21 of the Life Insurance Act 1995 or a general insurance company or Lloyd's underwriter authorised, or taken to be authorised, under the Insurance Act 1973[1].

The objective of providing insured benefits is to protect members against the risk of not being able to accumulate sufficient retirement savings, for themselves or their dependants, due to having to cease work as a result of injury, illness or Death.

2. COMPONENTS OF THE INSURANCE STRATEGY

When determining the kind of insurance benefits to offer, the Trustee has considered factors including, but not limited to:

- The anticipated future needs and benefits required by the membership
- The insurance benefits historically offered
- Insurance benefits offered by competitors
- Generally accepted insurance requirements including adherence to recommendations set out in relevant industry guidance notes and papers
- Regulatory requirements and the provisions of the SIS Act and relevant legislation

The Trustee's IS addresses the following:

- the kinds of insurance that are to be offered to, or acquired for the benefit of beneficiaries
- the levels of insurance cover to be offered to, or acquired for the benefit of beneficiaries

[1] SPS250, July 2022, paragraph 5(a)

- the basis for the decision to offer or acquire insurance by having regard to the demographic composition of the beneficiaries based on analysis of data regarding beneficiary cohorts and attributes
- the method by which the insurer is to be determined
- the cost to all beneficiaries of offering or acquiring insurance of a particular kind and at a particular level and ensuring it does not inappropriately erode the retirement income of beneficiaries, notwithstanding the ability for member's to actively opt-in to and/or elect to maintain member paid insurance cover

In accordance with APRA's expectations outlined in SPS 250, the IS demonstrates consideration of:

- the duty of the Trustee to ensure that the insurance arrangements and insurance outcomes are in the best financial interests of its beneficiaries
- the relevant factors in relation to the selection and appointment of an insurer and how the risks relating to this selection are to be managed
- when insurance cover is to commence, and how this has been aligned with the PMIF legislation and the circumstances under which a member's eligibility for insurance cover would cease, including in circumstances aligned with the PYS legislation
- the level of underwriting needed for beneficiaries to be provided with insured benefits
- the administrative capabilities for ease of underwriting and claims processes
- instances in circumstances of a successor fund transfer and how existing insured benefits are to be preserved
- how the Trustee monitors the overall number and profile of beneficiaries covered under each insurance policy considering the factors in SPG 250
- the particular benefits and risks of using a general insurance policy, in relation to the possible selection of a general insurer or Lloyd's underwriter
- the risks involved where it is necessary to enter into arrangements with more than one insurer (or where part of the insured benefit is reinsured) for making insured benefits available, i.e. risks related to maintenance and communication of complete and accurate member data where provided by multiple parties
- how beneficiaries will be made aware of the duty of disclosure which applies as a proposed life insured under the insurance policy
- how the Trustee will discharge its obligation to do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary, if the claim has a reasonable prospect of success
- the Trustee's approach to claims management, aligned to the recommendations set out in the ASFA Guidance Note for Claims Handling[2]
- the processes for monitoring, reviewing and renewing the insured benefits made available to beneficiaries
- the Trustee's approach to conflicts that may arise through making available insured benefits to beneficiaries in line with the Trustee's Conflicts Management Framework.

The IS covers the terms that must be documented in the Trustee's insurance arrangements in accordance with the minimum standards in SPS 250 and APRA's expectations in SPG 250.

[2] ASFA Guidance Note, Claims Handling, 30 June 2021

APRA has additional expectations in SPG 250 whereby an RSE licensee's IS, insurance arrangements and other documents in place prior to the commencement of risk address the following:

- underwriting requirements, including the responsibilities of the insurer, the Trustee or any other party
- any reduction in benefits and premium loadings, i.e. extra premiums charged to a member or group of beneficiaries based on specific conditions, including how beneficiaries are notified about additional premiums
- clearly defined conditions for when claims will be admitted or denied
- procedures for deducting premiums from beneficiaries' accounts and paying premiums to insurers
- procedures for notifying and paying claims, including the responsibilities of the insurer when communicating directly with beneficiaries
- continuation options (continuing of cover) including notification to beneficiaries
- liability and indemnity where the insurer outsources a material business activity relating to the insured benefits made available by the Trustee
- liability and indemnity where incorrect data has been relied upon
- profit-sharing arrangements and experience commission terms, including their consistency with the undertaking provided under section 29SAC of the SIS Act in relation to members with an interest in a MySuper product.

Insurance in Super Voluntary Code of Practice (the Code) and Guidance Notes

In March 2018, the Trustee became a signatory to the Insurance in Superannuation Code of Practice (the Code). The objectives of the Code were to address key issues identified within the insurance industry, including but not limited to:

- inappropriate erosion of account balances
- automatic cessation of cover
- claims handling principles
- monitoring and compliance of the Code requirements.

The Code was withdrawn on 30 June 2021 and replaced by industry Guidance Notes on claims handling and vulnerable members. Consideration and implementation of the recommendations set out in the relevant Guidance Notes have been incorporated into the Trustee's IS.

3. CONFLICTS OF INTEREST

The Trustee has a Conflicts Management Framework (CMF) established in accordance with the requirements of *Prudential Standard SPS 521 Conflicts of Interest.* The Trustee is mindful of its obligations regarding any conflicts of interest, whether potential or actual. This includes conflicts which may arise through the offering of insured benefits, including the selection of an insurer. All conflicts are dealt with under the Trustee's CMF.

4. TYPES AND LEVELS OF INSURANCE

The Fund offers Death (including Terminal Illness[3]), TPD and IP insurance cover. The insurance available (either as default or voluntary cover[4] through underwriting) aims to offer beneficiaries financial support during periods of temporary and permanent disablement and also to support beneficiaries' dependants when a beneficiary passes away.

The default cover amounts and terms and conditions of the insurance cover provided to eligible members are set out in the applicable policy. The default cover has been determined in consideration of the demographics of the Fund, the affordability of insurance cover so as to not inappropriately erode member accounts, the legislative requirement for members to make an active choice to opt-into default member paid insurance cover, claims experience, market competitiveness and price.

In determining the appropriateness of the default cover amounts and terms and conditions of the insurance cover provided to members, the Trustee considers the following:

- **SIS Act** - the Trustee is generally required to provide minimum levels of default Death and total and permanent disability (TPD) insurance to all MySuper members on an opt-out basis, except where an election has not been made on an account which is deemed inactive and/or where the member is required to actively opt-in to default member paid insurance cover due to being under 25 years old and/or has an account balance of under $6,000, and to offer insurance to choice members.

- **Other legislative requirements** – the Trustee has updated its default insurance offering on an opt-in basis, so that eligible members can make an active choice to obtain member paid default insurance cover. This predominantly impacts Income Protection, and default Death and TPD insurance cover which is not subject to an employer paid arrangement.

- **The Trustee's strategic decision** - insured benefits made available to members are determined with reference to the collective best financial interests of members as a whole. This is demonstrated by considering the demographics of the Fund's membership from perspectives of age and gender distribution, work status, salary, employer contribution levels, claims experience account balance, expected time to retirement, probability of making a claim and the specific nuances of the Fund. Consideration is also given to the insurability of members outside of the default offering.

- **Demographics of the Fund** – the decision on the types and level of insurance currently provided has regard to the demographic composition of the members of the Fund.

- **Distribution** – the fund demographic remains consistent and rates for the default levels of cover for Death and TPD have been negotiated taking into consideration that:

[4] Means insurance cover that is obtained by satisfying the insurer's underwriting requirements and which is not top-up cover or default cover as defined by the applicable policy.

- In terms of age distribution, the highest percentage of members are within the 35-44 age bracket (18.3%), followed by members in the age bracket 50-54 (12.6%) as illustrated in the table below (effective June 2022):

	Age Band										
	<25	**25-34**	**35-44**	**45-49**	**50 - 54**	**55- 59**	**60 - 64**	**65 - 69**	**70 - 74**	**75- 84**	**85+**
Accumulation Members	2712	9352	16395	9729	10635	9184	7493	5558	2843	1108	16
Defined Benefit Members	0	0	33	319	711	777	2682	4479	3608	2041	56
Total Members	**2712**	**9352**	**16428**	**10048**	**11346**	**9961**	**10175**	**10037**	**6451**	**3149**	**72**
Percentage of Total members	3.0%	10.4%	18.3%	11.2%	12.6%	11.1%	11.3%	11.2%	7.2%	3.5%	0.1%

The Trustee is aware that a Death or TPD benefit payment may consist of both an insured component and the member's account balance. As a member's age increases, the sum insured component typically reduces whilst their savings component typically increases. This is relevant for the purpose of trying to ensure that member and beneficiary needs can at least be partially met through insurance, in the event of Death or TPD, as these are lump sum payments which can significantly assist a member or the beneficiary in times of financial need.

Eligibility for default cover

MySuper members of Division 6 - Corporate Plus will be provided with default insurance cover if they meet the default cover conditions, and the following eligibility criteria as outlined in the applicable policy. Insurance cover provided automatically is on an opt-out basis.

<u>Death & TPD cover</u>

- Either:
  - have joined as a deemed member of Division 6; or
  - in any other circumstances permitted by the Fund's trust deed, have become a member of Division 6;
- be at least 15 years old;
- be an Australian resident;
- be under 65 years old;
- be employed by the principal employer or by an associated employer;
- join the relevant division within 120 days of commencement of employment; and
- be at least 25 years of age and have an account balance of $6,000, unless:
  - the member has made an election; or
  - an exception applies.

<u>IP cover</u>

- Either:
  - have joined as a deemed member of Division 6; or
  - in any other circumstances permitted by the Fund's trust deed, have become a member of Division 6;
- be at least 15 years old;
- be an Australian resident;
- be under 65 years old;
- be employed by the principal employer or an associated employer and must not be employed on a casual basis;
- join the relevant division within 120 days of commencement of employment;

- be at least 25 years of age and have an account balance of $6,000, unless:
  - the member has made an election; or
  - an exception applies; and
- advise a binary gender, male or female, within 120 days of commencement of employment. If a member advises they are non-binary, default cover is provided at the higher premium rate of male or female dependant on their age.

The following exclusions and limitations apply to IP cover:

- No benefit in respect of an insured member if total disability or partial disability is directly or indirectly caused by:
  - any war or act of war;
  - the insured member's intentional self-inflicted act or attempted suicide (whether sane or insane at the time); or
  - pregnancy unless disability continues for longer than 3 months after the pregnancy ends in which case disability will be considered to have started at the date the pregnancy ends.

- An exception means:
  - a defined benefit member; or
  - an employer sponsored member whose employer makes contributions to the fund in addition to its superannuation guarantee obligations and covers the full cost of the insured member's default cover,
    in accordance with the SIS Act.

Default cover conditions

All default cover is subject to the following default cover conditions:

- New employees must join TelstraSuper within 120 days of commencing their employment, otherwise all cover is subject to application and acceptance. Cover commencing outside usual conditions is subject to at work requirements and other eligibility criteria, conditions and exclusions contained in the policy.

- New members who are under 25 years of age or have an account balance that is less than $6,000 must make an election to opt in within 120 days of commencing employment to receive member paid default cover.

New MySuper members of Division 4 – Personal Plus can select Death only or Death & TPD age-based default cover on an opt-in basis if they complete an insurance declaration and pass all eligibility questions. These members may also apply for voluntary Death & TPD cover and IP cover by completing a full personal statement and are subject to underwriting by the insurer.

Appendix A outlines all details on categories and levels of default cover offered, including the applicable terms and conditions, for all divisions of the Fund.

Accumulation members are required to opt into any member paid default cover that they are eligible for within 120 days of commencing employment and are able to opt-out of any default cover received within 30 days of joining the Fund. Accumulation members who opt out within 30 days of receiving insurance cover will receive a refund of any insurance premiums that were charged.

Division 6 - Corporate Plus members also have a second opportunity to opt into member paid default cover which they are eligible for, when they reach age 25 and have an account balance of at least $6,000.

In addition to the above, eligible members have access to apply for voluntary cover through a variety of means including via full personal application underwriting, the transfer of existing external cover with another life insurer or superannuation fund and increasing existing cover following a specified life event (subject to completing a limited underwriting/ health questionnaire).

When promoting additional insurance cover to our members, the Fund will target any promotion to those segments of our membership for whom we have identified the cover is generally likely to be appropriate, affordable and of value.

Externally Insured Defined Benefits

The Death and TPD benefits provided to defined benefit members are calculated by reference to a formula based on the date the member would have retired using a "Benefit Multiple" up to the date of Death or TPD, plus a "Prospective Benefit Multiple" which represents the period of time between the date of Death or TPD and the date the member would have reached retirement age (as defined in the Fund's Trust Deed).

The member's Benefit Multiple grows over their entire membership of the defined benefit division. The member's Final Average Salary is also used in the calculation of the benefit accounting for inflation risk. The details of the formula are prescribed by the Fund's Trust Deed.

Defined benefit members may not opt out of, or alter, default cover. Defined benefit members have access to voluntary cover through underwriting.

Part-time employees

Part-time employees are eligible for insurance cover on the same basis as other accumulation or defined benefit members, however, if entitled to an insured benefit, part-time employees generally receive a proportional benefit based on the pro-rata hours and salary multiple.

Casual employees

Casual employees are eligible for default Death only or default Death and TPD insurance cover on the same basis as other accumulation or defined benefit members. Casual employees are not eligible for Income Protection cover.

5. DEMOGRAPHIC COMPOSITION OF THE BENEFICIARIES OF THE FUND

The Trustee recognises that the purpose of life insurance is to assist with maintaining a member's living standard (or that of their dependant/s) if they suffer from a disability or pass away. The Trustee's goal is to provide greater security and services to its members, whilst also recognising that life insurance is an important part of a member's financial plan.

The Fund's Trust Deed contemplates the provision of externally insured benefits and required the provision of self-insured benefits (1 July 1990 to 25 September 2005) in relevant circumstances.

Section 62 of the SIS Act sets out the core and ancillary purposes for which a superannuation Fund may exist. Section 62 specifically provides that one of the core purposes of a superannuation fund is the provision of death benefits. Ancillary purposes include the provision of disability benefits.

The SIS Act and Regulations made under that Act, together with APRA's SPS 160 and 250, restrict and prescribe the types of insurance that can and must be offered.

Furthermore, Choice of Fund legislation makes it compulsory for employers to offer their employees a default superannuation fund which offers a minimum level of default only insurance cover.

It is with these factors in mind, and having regard to its legislative obligations, that the Trustee offers its membership the types of insurance set out in the tables described above.

In accordance with the review process undertaken by the Trustee, it has considered the demographics of its membership to provide suitable insurance to meet the needs of its membership (with respect to both default and voluntary cover).

The Trustee considers member needs at various life stages to determine a appropriate levels of cover. Members also have the option to tailor cover based on their individual needs.

6. COST OF INSURANCE DOES NOT INAPPROPRIATELY ERODE THE RETIREMENT INCOME OF MEMBER/BENEFICIARIES

At a minimum of at least every 3 years the Trustee undertakes an extensive review to ensure the Fund's insurance offering remains competitive and appropriate. This analysis takes into account the demographic composition of the members of the Fund to ensure the insurance offered is tailored to, and continues to meet, the needs of beneficiaries. It also includes reviewing the type, level and cost of the current insurance offering to ensure members' retirement incomes are not inappropriately eroded.

Currently some employers pay the insurance premiums for eligible Division 6 - Corporate Plus members' default Death and TPD insurance cover[5]. Eligible Division 6 members are those members whose default Death and TPD cover is calculated by reference to their salary (which is generally expected to increase by at least the Consumer Price Index each year). As such, these members are afforded protection against inflation risk without their retirement income being inappropriately eroded.

Income Protection premiums are generally paid by the member. However, as there is a direct correlation between a member's level of Income Protection cover and their salary in Division 6, the risk of inappropriate erosion of benefits through premium deductions is mitigated.

[5] From the date the Fund offers a MySuper product some employers may continue to pay the insurance premiums for eligible TelstraSuper MySuper members.

This risk is further reduced by regular super guarantee contributions generally being paid into a member's account during a period when their benefit is in the accumulation phase, as well as the requirement on members to actively opt-into default member paid Income Protection cover within 120 days of commencing employment and the ability to opt out within 30 days of receiving this cover.

In the most recently available data, it's observed that premiums for Division 6 - Corporate Plus default Death and TPD cost are at the high end for most ages (reflecting high cover amounts), before trending towards the lower range at the oldest age (reflecting comparatively lower cover at these ages).

Member's retirement income is protected from erosion due to insurance premiums, as the premium arrangement is largely employer paid.

With respect to the cost of premiums for default Death and TPD cover in Division 4 – Personal Plus, given this age-based cover is set as a level premium, the price of insurance will not change as the member increases in age. From this analysis it is clear that across 23 funds in the industry, TelstraSuper falls within the lowest annual premium band across the age groups at $122.72 per annum for age-based Death and TPD cover.

From 1 July 2020, members who have transferred from the accumulation employer sponsored division (Division 6) receive a multiple of Division 4 – Personal Plus age-based units of cover to match the level of cover previously held, thereby ensuring continuity of cover and protection, with the ability to reduce these cover levels at any time. Premiums for members nearing retirement are generally higher. This represents a higher claim risk for members in this age group.

From 1 July 2020, casual employees of Division 6 – Corporate Plus pay $2.17 per week for default Death and TPD insurance cover. One of the Trustee's objectives is to offer quality low-cost insurance to as many members as possible. Casual members of this division are required to opt-into this default Death and TPD insurance cover within 120 days of commencing employment and can opt out within 30 days of receiving this cover.

RetireAccess members can apply for age-based Death cover from 1 July 2020 at a cost of $1.13 per week. Similar rationale to that used for the other division insurance offerings is applied to the Death only cover offered to these members.

As Divisions 2 and 5 (DB) are employer supported, no premium is payable at a member level for default cover and any associated expenses are met out of the DB pool. The Trustee has determined, on advice from the Fund's actuary, that the Fund must hold a reserve, with a minimum level of $1 million, to cover the payment of future Death and permanent disablement claims of DB members where a claim event has occurred between 1 July 1990 and 25 September 2005. This reserve is in addition to the allowance for a notional premium included in the employer's contribution rate.

In relation to the reserve described above, the Trustee will:

- at least every three years obtain an actuarial review of these arrangements;
- include an assessment of the adequacy of the amount of the reserve to meet liabilities. This review will also provide sufficient information on the arrangements described above to demonstrate the extent and adequacy of the actuarial oversight undertaken on those arrangements;

- satisfy itself annually that these arrangements continue to operate in the best interests of beneficiaries; and
- have regard to any input received from stakeholders, such as the Fund's actuary and Principal Employer.

By way of the processes outlined above, the Trustee ensures that all member-paid insurance, including voluntary and IP cover, is competitively priced and can be acquired, maintained, increased or cancelled at the member's discretion (subject to underwriting and any other applicable restrictions or limitations).

Protecting Your Super (PYS) legislation

On 1 July 2019, the Australian Federal Government introduced the Protecting Your Super (PYS) legislation which is aimed at avoiding the erosion of retirement savings for members who hold member paid insurance cover through superannuation.

The PYS legislation requires members whose accounts are considered inactive[6] for a period of 16 continuous months, to make an election to maintain any member paid insurance cover in that account. In the absence of an election, the member paid insurance cover will be cancelled by the Trustee.

Impacted members are notified at 3-month intervals that their account is becoming inactive (9, 12 and 15 months) and that they are at risk of losing their insurance cover without an election. If a member has lost their member paid insurance cover due to PYS inactivity, they are able to recommence this cover without underwriting subject to a request in writing within 30 days of the cover being cancelled. Outside of this timeframe, members are also able to re-apply for member paid insurance cover via underwriting.

Probability of making a claim

The risks or likelihood of making a claim are reflected in the mortality and morbidity rate tables provided by the Australian Bureau of Statistics. The Trustee takes into consideration the mortality and morbidity rates when determining the appropriate insurance offering.

Insurance Rates – 1 July 2023 to 30 June 2026

The Trustee's current insurer, MLC Limited (**MLC**) undertook the annual review of claims experience based on data effective 1 March 2022, inclusive of claims experience data from the previous insurer, TAL Life Ltd (**TAL**).

MLC found that claims experience was generally favourable across Death, TPD and IP, particularly in Division 4 – Personal Plus. On this basis and noting that the Trustee had agreed to enter a new 3 year contract renewal with MLC, new insurance rates, particularly for IP, were successfully negotiated for 1 July 2023 to 30 June 2026.

A discount of 14% on IP premium rates will be applied from 1 July 2023 to 30 June 2026, and all other rates will remain unchanged. That is, there is no increase or decrease to

[6] Inactivity is defined as an account which has not received monies such as contributions or roll ins (but excluding investment earnings) for the previous 16 months. Excluded from the legislation are employer paid insurance arrangements and Defined Benefit members.

Group Life rates, on the basis that the current Group Life rates continue to be comparable in the market.

Re-shaping of the IP premium rate was also considered, by apportioning between 11.8% and 30% of the discount to female IP premium rates for members aged between 41 to 65, and 11.5% of the discount to males of all ages and females below the age of 40.

This addresses an inequity of IP rates observed between genders at various age bands due to historical claims experience with TAL, with favourable IP rate re-shaping for both males and females, and particularly for females, as they near retirement age.

7. CLAIMS MANAGEMENT

The Trustee is mindful of the importance of insured benefits to the welfare of members and their beneficiaries. The Fund's IMF reflects the Trustee's commitment to ensure eligible members' benefit entitlements are realised.

The Trustee will undertake a regular review to ensure the interpretation and application of our definitions are consistent with any changes in our policy terms, and our insurers' approach.

The Trustee aims to adhere to ASFA's Claims Handling Guidance Note, derived from the Insurance in Superannuation Voluntary Code of Practice (the Code), which sets out a number of measurable recommendations relating to insurance arrangements in superannuation, including:

- Claims and complaint handling principles (i.e. governance; turnaround times, eligibility assessments, and adhering to a claims philosophy)
- Standard time frames for superannuation fund claims
- Enhanced communications throughout the claims process (i.e. insurance and claim process education, providing a primary contact during the claims process, using technology better to update claim status, and customer/member friendly communications)
- Claims handling governance
- Monitoring and reporting of any compliance breach in relation to claims handling.

The Trustee has incorporated aspects of the above proposals in its long-term claims philosophy (refer to Appendix B and C), claims processes, business rules, systems and overall claims management strategy

The Claims team has responsibilities for the day-to-day administration of insured benefits. The team is responsible for co-ordinating and collating information required by the Trustee to consider and determine all claims. This includes member and beneficiary claim forms, medical and employer reports and any other information necessary to allow the Trustee to properly consider and determine a claim in accordance with its legal and fiduciary obligations. All externally insured claims made are independently reviewed and determined by both the insurer and the Trustee.

In accordance with the relevant provisions of TelstraSuper's Instrument of Delegation, all claims are independently considered by the Trustee sitting as the CAC, delegated

Trustee Directors sitting as the MEC or, if necessary, the full Trustee Board. Declarations of any existing or potential conflicts of interest are sought from all relevant attendees.

The Claims team works closely with the Fund's insurer on all claims that are externally insured and assists with, and monitors, the insurer's administration of such claims.

An Insurance Service Standards Agreement (ISSA) between the Trustee and its insurer promotes the effective administration of externally insured claims. In addition to this, the Trustee and its insurer have a complaint review process should there be disagreement regarding the eligibility of a member or beneficiary to an insured benefit.

The Trustee has a review process in place for all rejected and/or disputed claims. This includes where appropriate, affording procedural fairness to members and potential beneficiaries and the independent review of claims by the Trustee sitting as the MEC.

As part of these processes the Trustee has in place procedures for ensuring that disclosure of any existing or potential conflicts of interest are declared. The TelstraSuper CMF provides details of this process.

8. INSURANCE SELECTION & RENEWAL PROCESS

The Trustee is mindful of the need to ensure its members have access to the most appropriate insurance arrangements available within the market and that the insurance arrangement is in the best financial interests of the beneficiaries[8]. Accordingly, the Trustee undertakes a full review of its incumbent insurer at least every 2 - 3 years. This full review may incorporate the Trustee using an insurance broker or third party provider to undertake a review and due diligence process of which meets the minimum requirements of SPS 250 and APRA's expectations in SPG 250:

- the kind of insurance offered to members;
- the level, or levels of insurance cover offered to members;
- the continued appropriateness of the insurance offering, having regard to the demographic composition of the members of the Fund;
- the method by which the insurer is determined (if appropriate);
- a review may be triggered by adverse events such as prolonged failure to meet agreed service standards or a loss of confidence in the insurer.

The Insurance Broker or third party provider's report is considered by the Trustee and the MEC at first instance. It will then be referred to The Board. Should the Board determine to undertake a full market tender, the report will generally form the basis of the tender document including the request for proposal provided to potential insurers.

If the Board determines to undertake a full market tender, the Trustee must develop and implement a selection process for choosing the incumbent or alternative insurer that includes, at a minimum, the following:

The scope and basis of the review

- objectives and goals of the review
- the measures to be used to define a successful outcome

Understanding the context for the review

[8] SPS250, July 2022, paragraph 24

- the group insurance market background
- trends and anticipated future changes
- the current insurance offering, including any points of differentiation
- any operational or other constraints that may need to be accommodated or countered

Agreeing on preferred insurance design & claims philosophy

- considering all elements of the insurance arrangements
- ranking and weighting these elements according to the extent to which they support or are aligned with the Trustee's strategic objectives
- ensuring that the future insurance provider offers a policy that matches the current offering, thereby ensuring there is no risk of the Trustee having to self-insure any gaps between the policies
- consideration of terms of cover and exclusions
- consideration of the prospective insurer's claims philosophy which includes:
    - the insurer's history of rate of rejection of claims
    - the insurer's record of claims decisions being overturned by the SCT or AFCA
    - the reasonableness of the insurer's claims requirements
    - the training and skills of the insurer's claims assessors
    - specific examples of claims paid and claims denied
    - the processes which support procedural fairness for claimants
- the reasonableness of the premiums to be charged
- terms of any delegation to any other person of functions associated with making available insured benefits
- a due diligence review of the selected insurer including conflicts of interest, financial strength[9], internal control environment and business continuity arrangements
- be able to demonstrate the appropriateness of the selection process and due diligence review and how it was applied.

Assessing the suitability of insurers

The Trustee will consider prospective insurance partners to be assessed against all factors that influence the quality of the relationship between TelstraSuper, the insurer and the Fund's members. Any prospective insurance partner must confirm that FSC Guidance Note 11, Group Insurance Takeover Terms,[10] will apply and further undertakings to ensure no loss of cover occurs on transition to the new insurer.

The following matrix has been used by the Trustee to measure the suitability of insurers. The weighting for each criteria is aligned with the Fund's objectives as outlined in this IS:

[9] Assessment of financial strength will include an assessment of the insurer's capital position (including any external rating), reinsurance arrangements and solvency.
[10] FSC Guidance Note 11 Group Insurance Takeover Terms (May 2013).

Criteria	Weighting
Organisational background	10%
Strategic partnering initiatives	15%
Account management & SLA's	10%
Product & servicing	10%
Use of technology/ digital	10%
Pricing	15%
Terms & conditions	15%
Underwriting & claims services	10%
Quality, risk & compliance	5%
Total	**100%**

The Trustee will review the prospective insurance partner responses to the request for proposal and rate them accordingly:

Insurer response	Rating
Response **consistently exceeds expectations** and is considered benchmark/ best practice, will provide either enhanced functionality, improve efficiencies, deliver superior member experience or improve product offering	High
Response **meets expectations** and on average, exceeds common market practices and has the potential to increase functionality, may result in efficiencies, will improve overall member experience and may result in improved offering.	Medium
Response **inadequate** and does not meet minimum market/industry standards, does not improve functionality, efficiencies, member experience or overall product offering.	Low

If the Board decides not to undertake a full market tender, it will require the incumbent insurer to make a formal response to the request for proposal to allow the Trustee to make a decision about whether to initiate a full market tender for group insurance services into the future.

Factors considered in making the decision as to whether to initiate a full market tender include the incumbent insurer's:

- ability to meet the Fund's requirements as to the suite of insurance offerings it aims to offer its members;
- product enhancements proposed by the incumbent insurer;
- enhanced member service commitments, e.g. development/re-development of the member online experience, underwriting and claims management technology solutions;
- ability to provide cost efficiencies;
- claims history; and
- claims philosophy.

If the Trustee then determines not to undertake a full market tender, the Trustee, in conjunction with its insurance broker or third party provider, will undertake a comprehensive review of its existing arrangements.

The key objectives of this comprehensive review are to:

- identify gaps (if any) in the current cover and consider how they might be addressed;
- review the types of cover provided by each division and benchmark it against other comparable funds in the market;
- analyse the design of the insurance benefits offered in each division of the Fund and determine if it can be improved to better meet the needs of members;
- conduct age profiling to examine the possibility of offering members more flexible cover;
- determine how current insurance premiums compare to others available in the market and ensure the Fund obtains 'value for money';
- ensure the Fund's insurance offering is seen as a market leader in meeting members' needs; and
- provide insurance that is easy to obtain so that difficulty in obtaining insurance is not seen as a barrier for new members.

The Trustee requires that the incumbent insurer is able to satisfactorily meet the key objectives of any review it may undertake.

As part of its insurance renewal process, the Trustee strives for operational excellence and opportunities to continuously improve its service model in the following areas:

- Technology
- Underwriting
- Claims
- Product Enhancement
- Fund Development and Marketing
- Policy and other associated documentation.

The process undertaken is demonstrative of the Trustee acting in the best financial interests of its beneficiaries by conducting an arm's length review. Declarations of any existing or potential conflicts of interest that may arise during this process are sought from all relevant personnel, including directors, and dealt with in accordance with the Trustee's CMF.

The Trustee also endeavours to obtain competitive premium rates for its members keeping in mind the need to ensure that premiums will not unduly erode beneficiaries' retirement savings. The rates and terms of insurance offered to members are negotiated as part of the tender or review process undertaken in conjunction with the Trustee's insurance broker or third party provider.

The Trustee will evaluate the insurer's honesty, fairness and transparency in its decision making, respect shown to members and staff and timeliness of responses on an ongoing basis.

9. INSURANCE ARRANGEMENTS[11]

Regarding its externally insured benefits, the Trustee enters into a written contract(s) (in the form of a policy) with the selected insurer, which details the types and levels of insurance for Fund members at the premium rates negotiated for the Group Life and IP policies. The following checklist covers the terms that must be documented in the RSE licensee insurance arrangements in accordance with the minimum standards in SPS 250 and APRA's expectations in SPG 250.

The external policies are evidence of the contracts of insurance entered into between the Trustee and the selected insurer. At a minimum, the Trustee requires that these policies and any accompanying agreements address the following matters:

- the level and type of insured benefits made available, including any exclusions;
- the term of the insured benefits;
- automatic acceptance limits;
- availability of opt in and/or opt out cover;
- requirements for the beneficiaries' eligibility for, cessation of, and any reinstatement of entitlements to insured benefits where available;
- premium structure, including any variable components;
- procedures for notification and payment of claims;
- dispute resolution arrangements;
- agreed service standards;
- reporting requirements for monitoring agreed service standards;
- the provision of complete claims information on an annual basis as required Prudential Standard SPS 250 – Insurance in Superannuation;
- liability and indemnity arrangements; and
- review, termination and renewal provisions for the insurance arrangement.

The Trustee has documented the terms and conditions of its self-insurance arrangements including in its insurance business rules and member disclosure documentation. To the extent they are relevant, the matters listed above are addressed in these documents.

In addition, the Trustee's insurance arrangements or other documents that are in place prior to the commencement of risk must address the following additional APRA expectations in SPG 250[12]:

- insurance services agreements;
- claims handling agreements;
- service level agreements;
- premium setting and profit share agreements; and
- agreements with third party service providers such as administrators, where the agreement relates to making available the insured benefits

[11] SPS250, July 2022, paragraph 18

[12] SPS250, July 2022, paragraph 51. The Trustee follows these factors despite not requiring independent certification for any related party insurance arrangements.

The Trustee also negotiates and enters into an Insurance Service Standards Agreement (ISSA) with the selected insurer. Details of the insurer's obligations under the ISSA are set out in the section below.

The Trustee ensures compliance with its duty to activate upmost good faith during its dealings with the selected insurer.

10. PROCESSES FOR MONITORING INSURANCE ARRANGEMENTS

The Trustee requires that an ISSA or similar agreement exists between it and its insurer. The provisions contained in the ISSA are negotiated with the insurer along with the relevant group policies. Also, the Fund has documented Insurance Business Rules.

At a minimum, the Trustee requires that the ISSA contains provisions relating to the insurance cover provided by the insurer, including that the insurer will perform certain services, related to its obligations under the policies, in accordance with service levels (where applicable) and also include the following:

- the provision of monthly underwriting and claims operational reports containing service standards and service targets;
- at least annually provide a report which provides details of the payments made by the insurer for Death, TPD and IP claims during the period of the report;
- review of complaints and claims relating to the polices according to the procedures stated in the ISSA; and
- the provision of a dispute resolution procedure between the Trustee and the insurer.

The Trustee ensures it has sufficient and appropriate resources to manage and monitor its relationship with its insurer at all times, including by:

- conducting monthly and quarterly meetings with its insurer attended by Executive General Manager (as needed), Operations, Head of Insurance & Claims and Product Manager (as needed); and
- having in place a process for regular monitoring of performance under the insurance arrangements, including:
  - monthly progress reports to senior management against service levels; and
  - access to the insurer's real-time data portal

The Trustee must notify APRA as soon as practicable of any issues that it considers might materially affect its ability to make insured benefits available to beneficiaries.[13]

Where an insurance arrangement is terminated, the Trustee must notify APRA as soon as practicable and provide a statement about the transition arrangements and future strategies for continuing to make insured benefits available to beneficiaries.[14]

[13] SPS250, July 2022, paragraph 21

[14] SPS250, July 2022, paragraph 22

11. REVIEW

It is the responsibility of the Head of Insurance & Claims to review and update this document on an at least an annual basis and seek approval of all changes from the Board (as part of the overall independent IMF review) on recommendation of the Executive General Manager, Operations.

APPENDICES

Appendix A - Categories of default cover offered

Table 1A below sets out the types of default insurance cover available in each of the divisions of the Fund as at 1 July 2020.

TABLE 1A: DEFAULT INSURANCE OFFERED BY DIVISION AS AT 1 JULY 2020

Cover Type	Division 2 – DB (Closed)	Division 5 – DB (Closed)	Retire Access	Division 6 Corporate Plus (Casuals)	Division 6 Corporate Plus (Permanent^)	Division 4 Personal Plus
Death	ü	ü	ü*	ü*	ü*	ü*
TPD	ü	ü	×	ü*	ü*	ü*
IP	×	ü	×	×	ü*	×

* Default cover is subject to default cover conditions and/or limited underwriting for new members of the Fund.
^Means a person engaged under a contract of employment and includes a contractor

Table 1B below sets out the types of default insurance cover available in each of the divisions of the Fund offered with a MySuper product.

TABLE 1B: DEFAULT INSURANCE OFFERED BY DIVISION 1 JULY 2020

Cover Type	Division 2 – DB (Closed)	Division 5 – DB (Closed)	Retire Access	Division 4 – Personal Plus		Division 6 – Corporate Plus	
				My Super	Choice	My Super	Choice
Death	ü	ü	ü*	ü*	ü*	ü*	ü*
TPD	ü	ü	×	ü*	ü*	ü*	ü*
IP	×	ü	×	×	×	ü*	ü*

* Default cover is subject to default cover conditions and/or limited underwriting for new members of the Fund.

Levels of cover

Table 2A shows the levels of default Death, TPD and IP insurance offered as at 1 July 2020 and which vary according to the particular division of membership. Voluntary Death, TPD and Income Protection is available by application in all Accumulation divisions. For members of the defined benefit divisions, voluntary insurance cover is available under the accumulation policy.

TABLE 2A: LEVEL OF DEFAULT DEATH, TPD & IP BY DIVISION AS AT 1 JULY 2020

Cover Type	Division 2 – DB (Closed)	Division 5 – DB (Closed)	Retire Access	Division 6 Corporate Plus (Casuals)	Division 6 Corporate Plus (Permanent^)	Division 4 Personal Plus
Death	Formula Based	Formula Based	Age Based*	Age Based*	Formula Based*#	Age Based*
TPD	Formula Based	Formula Based	X	Age Based *	Formula Based*#	Age Based*
IP	X	Formula Based	X	X	Formula Based*#	X

*Default cover is subject to default cover conditions and/or to limited underwriting for new members of the Fund.
^Means a person engaged under a contract of employment and includes a contractor
Formula based default Death & TPD cover is calculated according to a Multiple of Salary X Salary for Insurance Purposes and Age. Formula Based default IP is based on 75% of salary (excluding super) with 10% of salary (excluding super) to be paid into an eligible member's superannuation account. Members aged between 61-64 receive Aged Based default cover. Casual Division 6 Corporate Plus Choice and My Super members will receive age based Death & TPD cover.

Table 2B shows the levels of default Death, TPD and IP insurance which will be available in each of the divisions of the Fund offered with a MySuper product. Voluntary Death, TPD and Income Protection is available by application in all Accumulation divisions. For members of the defined benefit divisions, voluntary insurance cover is available under the accumulation policy.

TABLE 2B: LEVEL OF DEFAULT DEATH, TPD AND IP BY DIVISION

Cover Type	Division 2 – DB (Closed)	Division 5 – DB (Closed)	Retire Access	Division 4 – Personal Plus		Division 6 – Corporate Plus	
				My Super	Choice	My Super	Choice
Death	Formula Based	Formula Based	Age Based*	Age Based*	Age Based*	Formula Based*#	Formula Based*#
TPD	Formula Based	Formula Based	X	Age Based*	Age Based*	Formula Based*#	Formula Based*#
IP	X	Formula Based	X	X	X	Formula Based*#	Formula Based*#

* Default cover is subject to default cover conditions and/or to limited underwriting for new members of the Fund.
# Formula based default Death & TPD cover is calculated according to a Multiple of Salary X Salary for Insurance Purposes and Age. Formula Based default IP is based on 75% of salary (excluding super) with 10% of salary (excluding super) to be paid into an eligible member's superannuation account. Members aged between 61-64 receive Aged Based default cover. Casual Division 6 Corporate Plus Choice and My Super members will receive age based Death & TPD cover.

Appendix B - TelstraSuper and the insurer's Joint Claims Philosophy [15]

Together with our insurer, our joint claims philosophy is to act in the best interest of TelstraSuper members and provide support in their times of need. We are committed to compassionately guiding members through the claims process. As TelstraSuper's insurer, MLC Life Insurance endeavours to make the right decisions and supports ethical and fair outcomes for TelstraSuper members.

Both TelstraSuper and the insurer will work together to:

- explain the claims process in simple and easy to understand terms
- assist you to complete the requirements of the claim process, based on your individual circumstances
- have your claim finalised as quickly and efficiently as possible.

TelstraSuper will act as your advocate to ensure that our Insurer and any other third parties involved in your claim also act in accordance with this philosophy.

We understand that this may be a difficult time, so we'll both do our best to make the claims process as straight-forward as possible for you, with consultants acting in a consistent, fair, professional and empathetic manner. If you are well prepared and you have all the information that we need, making a claim is usually straightforward.

[15] TelstraSuper, www.telstrasuper.com.au/products-and-services/insurance/making-a-claim

Appendix C - MLC Claims Assessment Philosophy[16]

Our Contemporary Claims Management Model

Our contemporary claims management model, and the team that uses it, is designed to put the customer first. Here are some of the key features of our model which emphasise the most important values in our claims philosophy:

1. Cross-functional claims teams – Our claims teams are set-up to ensure **better and faster customer outcomes** with claims consultants, lead consultants and recovery specialists (rehabilitation consultants) to ensure each team has the capability to holistically manage claims.
2. End-to-end claims model – We support our customers with a focus on **early intervention**, functional capacity, holistic case management, return-to-work and ongoing support processes.
3. Customer conversations - We focus on conversations (telephone calls particularly) to **understand our customers** as best as possible; we minimise use of claims forms wherever reasonably possible.
4. Case conferencing - Our case consultants and internal specialists regularly confer to provide **evidence-based management solutions** for each customer.
5. Long duration claims – We've created a specialist claims team to provide **support for customers** with claims that are longer in duration.
6. ClaimVantage – We've implemented an industry leading cloud-based claim management system, ClaimVantage. It delivers a single, streamlined view of the customer and their claim to provide our customers with an **easier, faster experience**.

[16] MLC Life Insurance, www.mlcinsurance.com.au/partnering-with-us/financial-advisers/our-claims-philosophy