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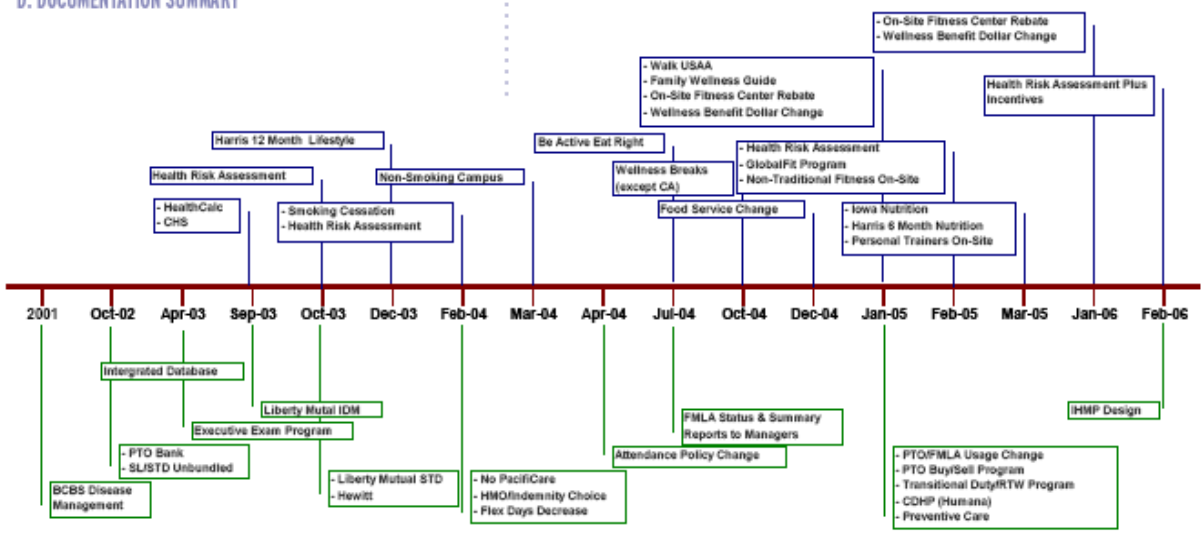
USAA's Wellness Program is building a wellness culture throughout the organization by creating an environment that promotes health and wellness for USAA's 22,000 employees and their families. The program brand, "Take Care of Your Health," pulls together more than 20 distinct program components described below.

A. Program Timeline

Figure 1 shows the evolution of the overall Wellness Program and the accompanying Human Resources and Benefits policy and program changes.

Figure 1:
USAA Wellness and Benefits Timeline



B. Customized Data Warehouse

The ability to manage Wellness Program components and measure their effectiveness is possible through USAA's integrated data warehouse, which is built around demographic, benefits consumption and participation data from all program initiatives and activities. The data warehouse provides risk information and is the primary information resource for population health management and identification of additional policy and health plan interventions.

All facets of the Wellness Program are monitored and measured at least quarterly for participation, trends in program use and outcomes. The effects of benefits and policy-design changes are also monitored quarterly.

C. Program Intervention Targets

The program's risk-based prevention efforts have three areas of focus:

1. Workplace Intervention—Workers' Compensation, leave and disability management.
2. Population Intervention—Building and sustaining a wellness culture around four core messages: Don't Smoke, Be Active, Eat Right, and Prevention.
3. Individual Intervention—High-risk/high-cost individuals.

1. Workplace Intervention

Prior to 2002, USAA's approach to time away from work resembled a traditional leave structure that included separate "buckets" and policies for annual leave, sick leave, restricted duty, extended medical leave, long-term disability (LTD), and Workers' Compensation (WC). In 2002, leave policies were consolidated into a paid-time-off (PTO) approach that combined annual leave and sick leave, and introduced an integrated approach to Family Medical Leave (FMLA), short-term disability (STD), LTD, and WC. In addition, an integrated WC task force was formed in 2003 with Corporate Safety to address workplace injuries, specifically repetitive motion injuries, which account for 48 percent of WC costs. An awareness campaign targeting employees and managers resulted in a 174 percent increase in visits to our intranet Ergonomic Information page, and a 46 percent increase in workstation adjustments from 2003 to 2005. In 2005, leave policies were further refined with the introduction of transitional duty.

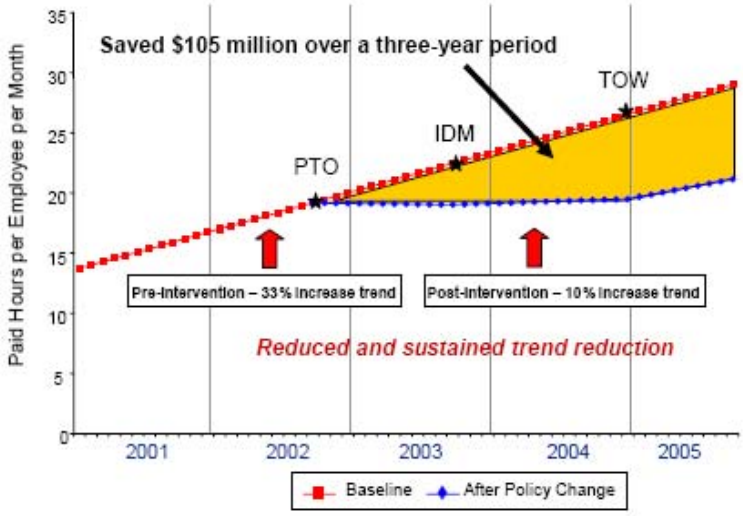


Figure 2:
Uses paid hours (PTO) absent per month, adjusted for seasonality.

a. PTO/Time-Away-From-Work Highlights:

- In 2005, 770 employees returned to work due to elimination of extended medical leave and the initiation of the transitional duty program.
- Also in 2005, 327 employees returned to work on transitional duty, with 630 days of productivity gained.
- These interventions resulted in a decrease in workplace absences, with an estimated three-year savings of more than $105 million. (Figure 2). Note that with the January 2005 policy change to mandate the use of PTO balances prior to any unpaid absence; the PTO rates are once again increasing. However, the net effect is a reduction in the company's liability for the time. There has been a corresponding 58 percent decrease in the use of unpaid time (November 2004 through November 2005).

b. Integrated Disability Management Highlights:

- Workers' Compensation reductions are shown in Figure 3. A 3 percent reduction in overall frequency, 8 percent in rate, and 24 percent in severity with 427 days of potential gained productivity.
- $1.5 million savings on annual LTD plan premiums.

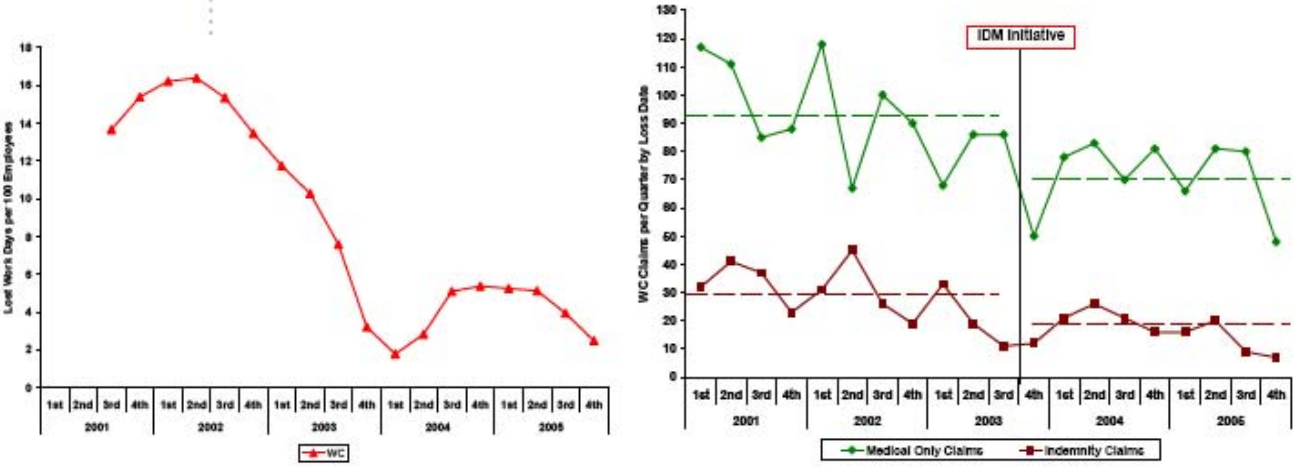


Figure 3: *Workers' Compensation experience in each quarter as a rate per 100 employees, and rate of claims by loss date.*

2. Population Intervention – Building a Wellness Culture

Participation in population-intervention programs has increased steadily (Figure 4). In 2005, 68.5 percent of the active USAA workforce participated in at least one of the wellness components for which data warehouse information is available. The HRA component is used to generate current program metrics against program-participation goals that were adopted from the Healthy People 2010 guidelines as described below. In addition, USAA provided Wellness Benefits of $300 in 2005 and $350 in 2006 to each employee family unit to help employees and eligible dependents quit smoking, manage their weight, and increase physical activity.

Figure 4:
Date employee first shows up in any wellness data captured by the data warehouse, including HRA, lifestyle counseling, and reimbursements for smoking cessation, weight management, and external gym memberships.

a. Participation Highlights:

Highlights of participation levels in other wellness components include the following percentages of active employees in 2005:

- Weight management – 9.4 percent (new program in 2005).
- Lifestyle management counseling – 6.7 percent (new program in 2005).
- On-site fitness – 33.1 percent (up from 15 percent in 2004).
- Off-site fitness subsidy – 9.2 percent (new program in 2005).

b. USAA 2010 Goals:

Using the Healthy People 2010 goals as a guide, USAA developed its own measurable program goals. Figure 5 shows those specific goals, and the status of progress toward each goal at the end of 2005.

Figure 5:
USAA program goals.

	2005	2010 goal
Participation	68.5%	75%
BMI 30 & above	33%	15%
Healthy Weight	33%	60%
Smokers*	8%	12%
Activity	17%	30%
Fruit intake	27%	75%
Vegetable intake	20%	50%
Work related injuries	1.50%	**0.95%
High blood pressure	24%	16%
Cholesterol*	14%	17%

*In the Smokers and Cholesterol categories, USAA has already exceeded its 2010 goals.
** USAA has set a goal for work-related injuries that is lower than the Healthy People 2010 goal.

c. Results From the Four Core Messages:

(1) Don't Smoke: Figure 6 illustrates the success of the smoking-cessation program where 66 percent of those in a formal program reported success (as represented by two HRAs taken at least six months apart). Figure 7 shows significant reductions in lifestyle risk scores. USAA's smoking-cessation goal is supported by the smoke-free campus policy (all internal and external work site areas) and the policy to eliminate prescription copays for smoking-cessation drugs.

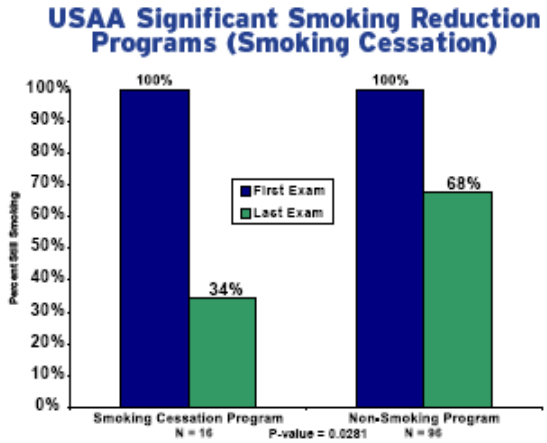


Figure 6:

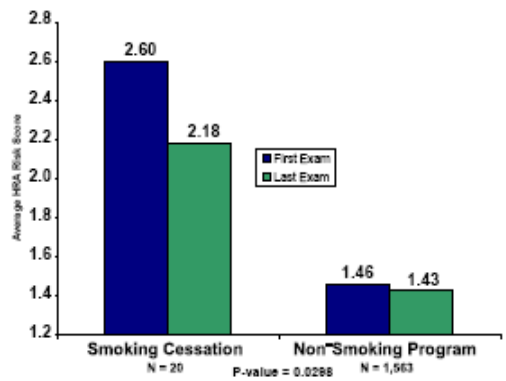


Figure 7:

(Please note that for figures 6, 7, 8, 9, 10, and 11, data are from two HRAs taken at least six months apart. Program participants are compared against non-program participants. A generalized linear regression model is used, adjusting for age, gender, marital status, salary, full-time status, and the beginning risk factors being compared.)

(2) Be Active: Figure 8 shows the usage of USAA's on-site fitness centers, and the resulting reports of reductions in lifestyle risk factors. The fitness centers are equipped with state-of-the-art exercise equipment and also provide shower facilities, exercise clothes, a variety of group exercise classes, and fitness staff who provide instruction and support. Enhanced programs, such as personal training and massage therapy, are offered at reduced cost. As an incentive to use their memberships, employees are rebated half of their membership costs if they visit an on-site fitness center at least twice a week.

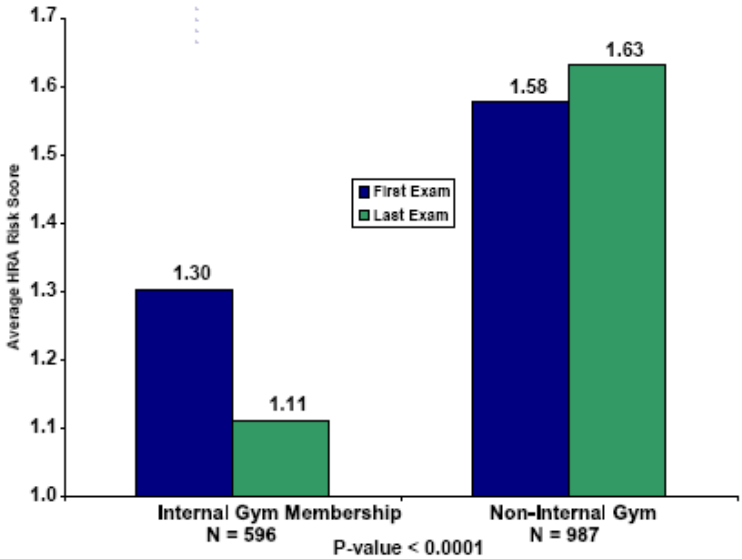


Figure 8:
USAA significant HRA risk score reduction programs-on-site fitness centers.

Gym Usage	Employees	Average Integrated Cost	Cost Difference from Core
Non-Members	15,701	$2,800	$1,323
Active Members	7,216	$2,151	$674
Core Members	1,551	$1,477	$0

Figure 9:
Based on number of visits per week to the on-site fitness center from Feb. 1, 2005, to Dec. 31, 2005. Active members are defined as less than two visits per week. Core members are defined as two or more visits per week. Costs are incurred between Jan. 1, 2005, and Dec. 31, 2005.

(3) Eat Right: USAA made a number of changes to make it easier for employees to eat right.

- All cafeterias provide comprehensive information about nutritional value and content of food choices.
- Health-conscious food choices were introduced and/or highlighted in the cafeterias and in related printed materials, online resources, and videos.
- All cafeterias have seen an increased utilization of the new menu choices.
- Vending machine choices were maintained with two significant differences:
  - Water, juices, fitness drinks, and sugar-free drinks were made less expensive than regular sodas, and
  - Water, juices, fitness drinks, and sugar-free soft drinks were moved to eye-level positions.

Together the "Be Active" and "Eat Right" program components help USAA employees attain and maintain their overall health and fitness. The programs do not focus on weight reduction per se, but HRA risk factors, especially for weight and/or BMI, are used for voluntary program referral to customized telephonic counseling services. This is an individually based intervention for employees identified as high risk through the HRA. Two programs, lasting six and 12 months each, focus on education and behavioral changes for employees with high BMI. Other lifestyle risk factors, such as smoking, physical inactivity, and poor nutrition, receive 12 months of education and support. Outcomes from the lifestyle counseling programs, represented in Figures 10 and 11, are based on comparative analysis of HRA responses taken at least six months apart.

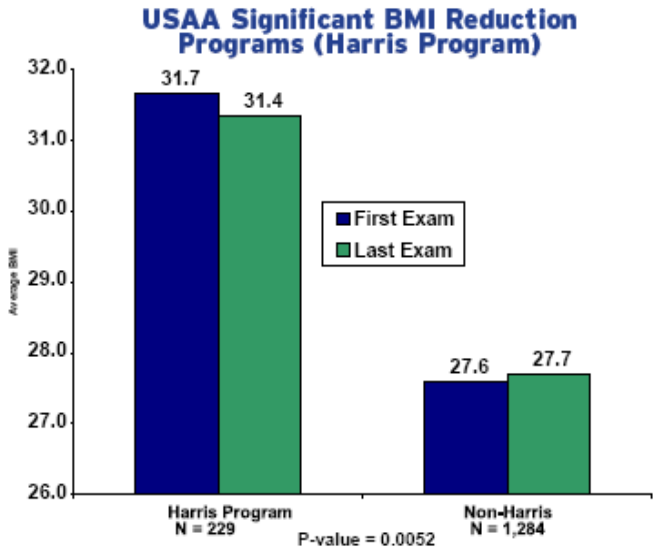


Figure 10:

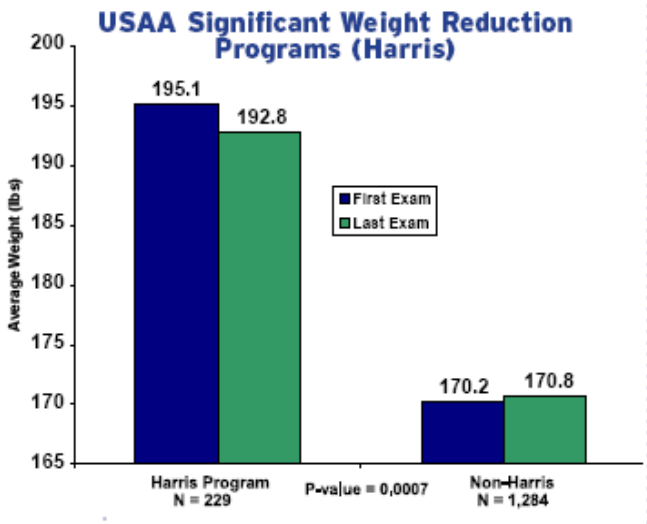


Figure 11:

(4) Prevention: Medical preventive services are part of USAA's health insurance plan design. Each medical plan participant has up to $300 to use during the calendar year for eligible preventive care services. United States Preventive Services Task Force guidelines are used to determine eligible benefits, and these preventive-care benefits are communicated to employees during open enrollment and throughout the year.

d. Reaching Scheduled Employees–Wellness Breaks:

Approximately 60 percent of USAA's employees work in a call-center environment that requires strict scheduling. In order to allow time for participation in various wellness activities, USAA provides "wellness breaks," which allows scheduled employees to combine their 35-minute lunch with one 20-minute break twice a week to allow two 55-minute wellness breaks each week (in every USAA office except Sacramento, where state labor laws do not allow combining breaks). This creative solution allows call-center employees to take advantage of the many at-work opportunities to improve their health.

e. Reaching Employee Dependents:

USAA's program includes employees' dependents in two notable ways:

- Employees can be reimbursed through USAA's Wellness Benefits for eligible dependents who participate in external smoking-cessation programs, weight-management programs, or external fitness centers.
- Employees' dependents are included in an annual health and wellness fair, which provides access to service providers, educational sessions and materials, as well as biometric and other screening exams.

f. Productivity:

The ultimate measure of program effectiveness is the effect on workplace productivity. The Work Limitation Questionnaire (WLQ) is included in each HRA to measure changes in demands in the following areas: physical, time management, mental/interpersonal, and output. An overall score measures the integrated/cumulative effect. Figure 12 shows the results with two HRAs taken at least six months apart. For the overall WLQ score, every 2 percent reduction in impairment yields a 1 percent gain in productivity. USAA's overall score decreased by 0.9 percent, which indicates a productivity increase of 0.45 percent. For 20,000 active employees, this corresponds to a productivity increase of 187,200 hours, or approximately 90 employees.

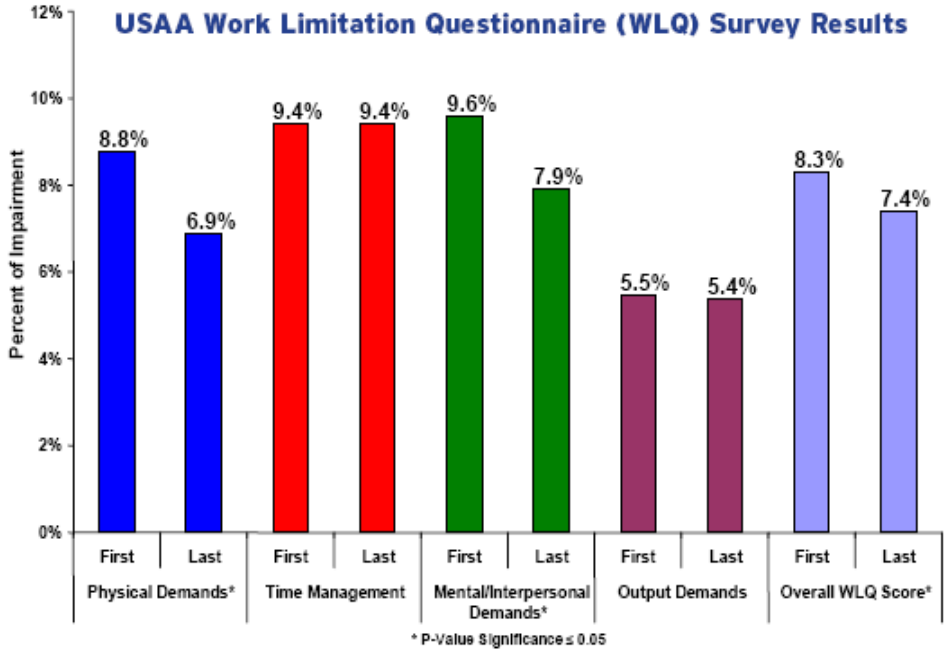


Figure 12:

Services	Pre CDHP 2004	Post CDHP 2005
Admissions per 1000 members	61	51
Average Length of Stay (Days)	3.9	3.2
Inpatient days per 1000 Members	238	163
OB Visits	22,913	22,980
Preventive Services (p<0.001)	$103	$126

Figure 13: *Health plan utilization comparison from 2004 to 2005.*

3. Individual Intervention

Ongoing analysis of our medical plan experience (2004 compared to 2005) indicates lower overall utilization for discretionary medical care without corresponding reductions in utilization for required care (e.g. OB visits) or preventive care (Figure 13). This experience is consistent with expected results from the new Consumer Driven Health Plan (CDHP) design. This plan design change resulted in a savings of $7.6 million in 2005 when compared with the previous health plan trend (Figure 14).

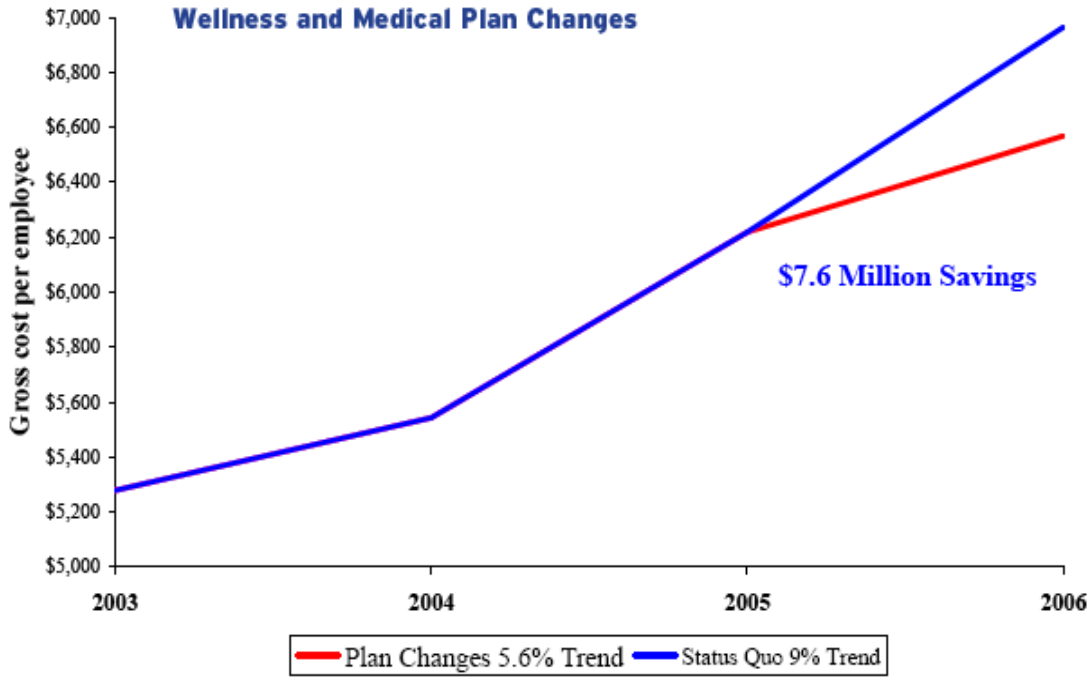


Figure 14: *Cost increases declined from 9 percent in the previous period (2002-2004) to 5.6 percent, and continue to be below the national trend of 12 percent increases.*

Additional evaluation of medical plan performance reveals a small number of high-risk participants responsible for a disproportionate share of the costs. This group, comprised of about 2.5 percent of participants, accounts for about 40 percent of total claims costs (Figure 15 below). To control costs attributed to this high-risk group and to assist participants, USAA is planning an additional intervention dubbed the Individual Health Management (IHM) service.

a. Individual Health Intervention:

The Individual Health Management (IHM) clinical-intervention service is a new initiative which will provide education and decision support for individuals who either have or who are at risk of developing:

- Multiple and/or complex medical conditions, and
- Polypharmacy (use of multiple medications without single provider oversight).

Employees are grouped in high, moderate, and low-risk categories using integrated analysis of resource consumption. Based on the Pareto concept that a small minority can consume the majority of resources, the consumption of integrated benefits is divided into five parts or quintiles of equal cost:

- High-risk groups are those using the highest two amounts of resources (fourth and fifth quintiles),
- Moderate-risk groups are those using the second and third largest amounts of resources, and
- The low-risk group is comprised of those employees using the lowest 20% of resources.

Figure 15 is an example of the Pareto group distribution, and Figure 16 is a trend of costs, which indicates that the long-term increase in costs is mainly attributable to the high-risk group.

Integrated Health Benefits Pareto

Quintile	Population	Claims Cost	Prevention	Cost Range	Medications
1	20,705 (84.6%)	$597	$57	$0-$3,524	3
2	2,182 (8.9%)	$5,660	$93	$3,524-$9,202	9
3	972 (4.0%)	$12,704	$83	$9,205-$18,043	10
4	466 (1.9%)	$26,506	$99	$18,115-$43,961	12
5	143 (0.6%)	$86,439	$89	$44,193-$525,552	16

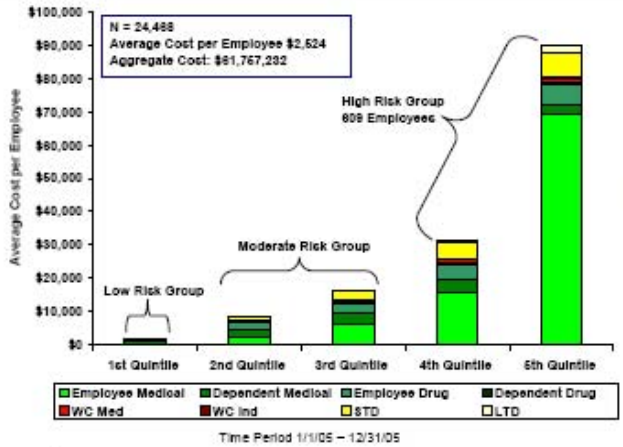


Figure 15: *Includes employees who worked at least one day in 2005. Costs are incurred between Jan. 1, 2005, and Dec. 31, 2005. Employees are sorted by integrated cost and put into 20 percent cost buckets. Costs for dependents are included after the employee is assigned a cost quintile.*

Integrated Health Benefits Trend by Risk Group

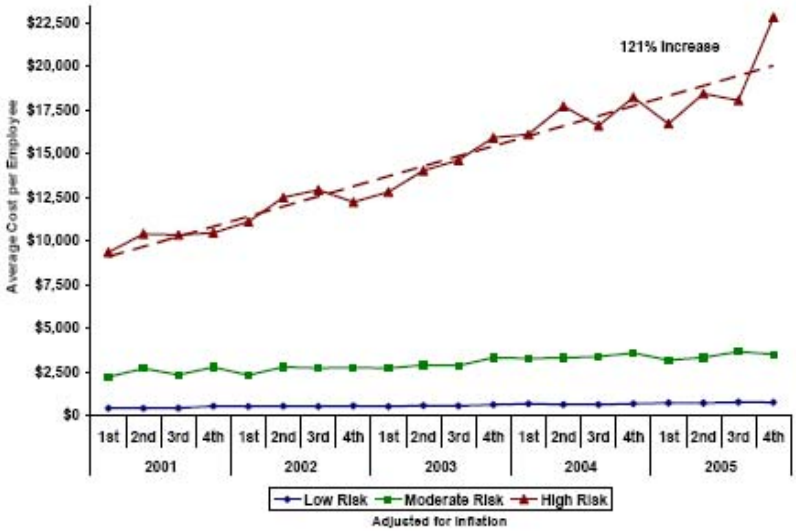


Figure 16: *Includes employees who worked at least one day in each quarter and includes costs that are paid in that quarter. Employees are sorted by integrated cost and put into 20 percent cost buckets. Costs for dependents are included after the employee is assigned a cost quintile. High risk includes the 4th and 5th quintile, moderate risk includes the 2nd and 3rd quintile, and low risk is the 1st quintile. All costs are adjusted for inflation.*

The IHM customized intervention service is possible because USAA is able to determine through the integrated data warehouse which employees are responsible for the greatest costs. The IHM service provides for a new model of tertiary prevention that is individually focused, cognitive, clinically competent, continuous (beyond an absence/illness episode), and concurrent with medical care received by the employee. Interventions will be provided telephonically by a masters' degree level nurse with pharmacist support.

Traditional disease-management programs have a singular focus on a disease, not the individual. In Figure 17, USAA research clearly shows that even with a primary diagnosis of Diabetes/Cardio/Metabolic conditions, the cost for co-morbid conditions is greater than cost for the primary diagnosis.

Employee Diabetes/Cardio Metabolic Integrated Disease Specific Pareto Report

Quintile	Population	Claims Cost	Cost Range	Medications
1	2,365 (76.5%)	$1,936	$0-$6,400	7
2	426 (13.8%)	$10,766	$6,401-$18,221	12
3	185 (6.0%)	$24,657	$18,255-$34,939	13
4	88 (2.8%)	$52,220	$35,014-$82,541	16
5	29 (0.9%)	$158,604	$84,808-$525,552	18

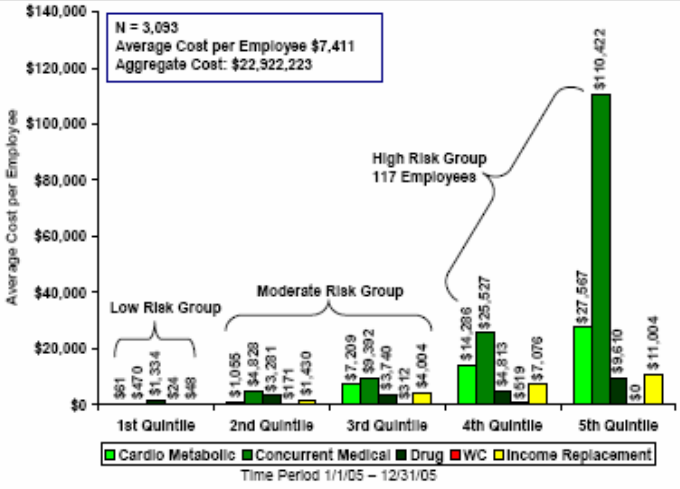


Figure 17: *Includes employees who worked at least one day in 2005 with costs incurred between Jan. 1, 2005, and Dec. 31, 2005. Employees are sorted by integrated cost and put into 20 percent cost buckets. Employees had a primary diagnosis of Diabetes/Cardio/Metabolic conditions, including Coronary Atherosclerosis and other heart disease, Cardio Vascular Disease (including hypertension), and Obesity.*

IHM will be implemented later in 2006 with a primary emphasis on prevention of continuing loss of productivity and possible clinical adverse events from fragmented care. The IHM service will be both a referral and outreach initiative.

D. Documentation Summary

USAA's Wellness Program represents the next generation of integrated employee health and disability support. The multiyear, multifaceted approach to worksite wellness measures population health, identifies interventions, measures program outcomes, and establishes cause-and-effect relationships between them. Program design incorporates participation levels and outcomes from the Healthy People 2010 guidelines. Because of the complexity of the benefits-strategy design, and the increasing number of wellness activities and participants, general and aggregate outcomes are monitored and reported routinely. "Take Care of Your Health" is having a significant impact on USAA's culture and on employee health and wellness, as measured by the change in the employee population's risk profile and by anecdotal feedback provided by individual employees.