SUMMARY OF MATERIAL MODIFICATIONS TO THE USAA DENTAL PROGRAM

This Summary of Material Modification ("SMM") is a supplement to the Summary Plan Description (the “SPD”) for the USAA Dental Program (the “Dental Program”), which is a component benefit program of the USAA Group Health Care Arrangement.

This document summarizes important changes to the Dental Program SPD. You should keep a copy of this SMM with your Summary Plan Description for future reference.

The following changes are effective 1/1/2013:

Summary Chart of Benefits for Delta Dental PPO Option (Page 12)

- Diagnostic and Preventive:
  - Space Maintainers have been moved to Basic Restorative Services

- Basic Restorative Services:
  - Denture repairs have been moved to Major Restorative Services.
  - (*) has been added to the 60% under Non-Delta Dentist column, which footnotes the following:
    - Ceramic porcelain restorations on posterior teeth are covered at 80%, whether In-Network or Out-of Network. Note: If a specific dental condition can be treated by two or more different services according to customary dental practice, the Delta Dental PPO option may consider a charge to have been incurred for the least costly of such services which would have produced a professionally satisfactory result.

What the Delta Dental PPO Option Covers (Page 13 - 14)

- Covered Diagnostic and Preventive Services
  - New item: Diagnostic & Preventive Services are not subject to the Calendar Year Maximum Amount.

- Covered Basic Restorative Services
  - Changed description of “Anesthesia” to “General Anesthesia”.

Claims (Pages 19-21)

- Applying for Delta Dental PPO Benefits
  - Updated phone number to 800-873-1051.

If you have any questions regarding this change, please contact the USAA Benefits Center at 1-800-210-USAA.

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USAA Dental Program

Summary Plan Description

2012

NOTE: This booklet merely summarizes key plan features and does not replace the legal plan document, which governs in the case of any differences or inconsistencies.
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Overview of Dental Program

USAA offers you and your eligible dependents the opportunity to obtain dental coverage under the terms of the USAA Dental Program (the “Dental Program” or “Program”).

Coverage Options

Each year when you enroll for coverage, you decide which dental option best meets your needs and the needs of your eligible dependents. The Dental Program offers you and your eligible dependents the following two dental coverage options:

- Delta Dental PPO (Preferred Provider Organization)
- Aetna DHMO (Dental Health Maintenance Organization)

Coverage Categories

If you decide to participate in the Dental Program, you may choose dental coverage for yourself and your eligible dependents by selecting from the following coverage categories:

- You Only
- You + Spouse or Domestic Partner
- You + Child(ren)
- Family (You + Spouse/Domestic Partner and Child(ren))

Paying for Coverage

Under the current cost sharing structure, USAA shares in the cost of your dental coverage by paying 50 percent of the cost of your coverage. You pay the other 50 percent for your coverage plus the full cost of coverage for your family members.

As an employee, your share of the coverage cost is deducted from each paycheck throughout the year before federal income taxes and social security taxes are calculated. Using before-tax dollars to pay for your coverage reduces your taxable income. Retirees should refer to the separate summary description booklet entitled “Upon Retirement” for information regarding premium payments by Retirees.

Relationship to USAA Group Health Care Arrangement (“Wrap Plan”)

The Dental Program is a component benefit program of the USAA Group Health Care Arrangement (the “Wrap Plan” or “Plan”) and is governed by the terms of the Wrap Plan and the Dental Program. The separate summary plan description booklet for the Wrap Plan provides additional information about the Plan, including important information that is applicable to the Dental Program.

This Summary Plan Description reflects the provisions of the Dental Program as of January 1, 2012. You may obtain a copy of the most current version of the summary plan description for the Program and the Wrap Plan by by visiting the MyLife website or by contacting the USAA Benefits Center at 800-210-USAA. In case the benefits described in this Summary Plan Description are different than those described in the official plan document for the Dental Program or the Wrap Plan, the terms of the official plan documents will control.

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Overview of Coverage Options

Aetna DHMO Coverage Option

The Aetna DHMO option offered under the Dental Program is insured by Aetna. Benefits available under the Aetna DHMO option are provided under a group insurance contract entered into between USAA and Aetna.

In addition to being responsible for paying claims, Aetna serves as both the Claims Administrator and named fiduciary responsible for making a final determination on your claim. All claims for benefits under the DHMO option are sent directly to Aetna. In general, the DHMO option offers you coverage for preventive, diagnostic, restorative and orthodontic services to maintain good dental health, but you should consult the certificate of insurance booklet issued by Aetna to determine the specific coverage available under the Aetna DHMO option. A copy of the certificate of insurance booklet issued by Aetna for the DHMO option may be obtained by visiting the MyLife website or by contacting the USAA Benefits Center at 800-210-USAA (8722). The coverage details described in the summary below applies to the Delta Dental PPO option, not the Aetna DHMO option.

One important requirement of the Aetna DHMO option is that, when enrolling, you must select a Primary Care Dentist (“PCD”). Prior to your selection, you should call the PCD to ensure they are participating in the Aetna DHMO network and are accepting new patients.

Delta Dental PPO Option

To give you more flexibility, the Dental Program also offers you and your eligible dependents a dental preferred provider option (PPO) with Delta Dental. Under the Delta Dental PPO option you may choose to go to any dentist. However, the Delta Dental PPO option provides maximum benefit when you visit a Delta Dental PPO Dentist. The coverage available under the Delta Dental PPO option is described in this summary.

To use the Delta Dental PPO, just call the dental office of your choice and make an appointment. During your first appointment, give your dentist your group number (TX-3791) and your social security number.

For a list of In-Network dentists in your area, search the dentist directory on the Delta Dental website: Connect > Benefits & Wellness > MyLife > My Health > View Benefit Provider Contact List > Delta Dental (this is single sign-on access). The direct website is: [http://www.deltadentalins.com/usaa/](http://www.deltadentalins.com/usaa/).

The Delta Dental PPO option is self-funded. A self-insured group health plan (or a “self-funded” option under a plan) is one in which the employer assumes the financial risk for claims. Self-insured employers pay for each claim as they are incurred instead of paying a fixed premium to an insurance carrier. This means that premiums you pay for the Delta Dental PPO option are deposited into a USAA trust. Benefit payments processed by the Delta Dental PPO are paid from this trust.

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Eligibility Requirements

Eligibility Requirements for Employees and Retirees

If you are a “Regular Employee” of a Participating Employer (as described in the separate summary plan description for the Wrap Plan), you are eligible to enroll in the Dental Program as an employee.

Retirees should refer to the separate summary description booklet entitled “Upon Retirement” for eligibility requirements for enrolling as a Retiree.

Eligibility Requirements for Dependents

If you are eligible to enroll in the Dental Program, your “Eligible Dependents” (as defined below) may also be eligible for coverage.

Your “Eligible Dependents” are the following individuals (as defined below).

1. Your Spouse
2. Your Child under the age of 26*
3. Your Domestic Partner

* A Child’s eligibility for coverage ends when the Child reaches age 26 unless the Child is unmarried, permanently disabled, incapable of self-support, and dependent on you for support and maintenance. In addition, the Child must have been covered under the applicable benefit program when he or she turned age 26. You must provide satisfactory proof of the Child’s incapacity within 31 days after the Child’s 26th birthday, and every three years thereafter.

In the case of the Aetna DHMO option, the age limit for an Eligible Child is determined by applicable state law. See the separate summary booklet that is applicable in your state for the Aetna DHMO option for more details about dependent eligibility for that option. If an Eligible Child is improperly denied coverage based on age, you should contact Aetna directly to have coverage reinstated.

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Your Domestic Partner is the same- or opposite-sex adult who is in a continuous, committed, and exclusive relationship with you, and who: (1) is not in any such relationship with any other individual (such as by legal marriage, common law marriage or domestic partnership); (2) is not related by kinship to you to a degree that would preclude marriage in the state in which you are domiciled; (3) has shared a principal residence with you for at least 12 months; and (4) is Financially Interdependent on you.

“Financially Interdependent” means meeting at least two of the following six standards: (1) jointly owning real property by deed, mortgage or lease; (2) jointly paying household expenses; (3) holding a joint bank account; (4) holding a joint credit card with the same account number; (5) having been designated by, or designating, you as an executor or beneficiary of a will; and/or (6) having been designated by, or designating, you as power of attorney.

You will be required to provide documentation satisfactory to the Plan Administrator within 60 days from your date of enrollment to verify the relationship of each dependent. Dependents which are not verified by the deadline will be removed from coverage.

If You and Your Dependent Both Work at USAA
You and your Eligible Dependents can be covered by only one person under the Dental Program. You cannot have double coverage under the Program for any family member. For example, if you and your spouse both work for USAA and you choose dental coverage for yourself and your children, your spouse must choose “You Only” coverage; however, eligible expenses will be combined for purposes of determining the family deductible.

**Enrollment and Effective Date of Coverage**

**Enrollment When You Start Employment**
During the first 31 days of employment, you may elect to enroll in coverage under the Dental Program or opt for no coverage. If you are a Regular Employee (see “Eligibility Requirements” section) on your date of hire and you enroll within 31 days of that hire date, your coverage will be effective on your date of hire.

**Enrollment of Retirees**
If you are a Retiree and you enroll within 31 days of your initial eligibility for the Dental Program, your coverage will be effective on the date of your initial eligibility as a Retiree. See the summary booklet “Upon Retirement” for more details.

**Changing Coverage and Benefit Elections**

**Coverage and Benefit Option Changes You May Make**
Once you enroll or fail to enroll in the Dental Program for you and/or your Eligible Dependents, you may make changes to that coverage (or non-coverage) status for you or an Eligible Dependent only (1) during any subsequent annual enrollment period or (2) during the Plan Year upon the occurrence of a “Permissible Mid-Year Election Change” event (as described below).

**Annual Enrollment and Passive Enrollment**
Eligible employees and Retirees may make a coverage change (including deciding which family members you want to cover) during each annual enrollment period.

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If timely and properly made, changes made during the annual enrollment period will be effective the next following January 1 (the “Annual Enrollment Date”). The annual enrollment period takes place prior to each Annual Enrollment Date. You will be informed of the dates of the annual enrollment period each Plan Year prior to the annual enrollment period.

**PASSIVE ENROLLMENT:** Once you have completed your enrollment under the Dental Program for the first time, you do not have to re-enroll in the Program during subsequent annual enrollments as a result of the “passive enrollment” feature under the USAA Cafeteria Plan. You will be required to pay for these carried-over coverages, so it is important to drop or change coverage or benefit options during annual enrollment if you do not want to be covered under the same coverage and benefit options for the following Plan Year.

**Note:** If a Dental Program option that is currently in effect is replaced with another option (the “replacement option”) for the following Plan Year (or is cancelled without being replaced), then, under the passive enrollment feature, you will be deemed to have elected coverage under the new replacement option (or the remaining option if there is no replacement option) for the following Plan Year, even if that option costs more than the option under which you were previously covered. You will be notified in advance if there is ever a replacement or cancellation of a Dental Program option. You also will have an opportunity during the annual enrollment period to override the passive enrollment feature and elect whichever option you prefer or opt for no coverage.

**Permissible Mid-Year Election Changes**

Upon the occurrence of a “Permissible Mid-Year Election Change” event that occurs after you become eligible for the Program, you may make certain enrollment and benefit coverage changes during the Plan Year outside the initial enrollment period and the annual enrollment period. Those Permissible Mid-Year Election Change events and the conditions that must be met to make the change are described in more detail in the summary plan description for the USAA Cafeteria Plan.

Subject to the requirements described in the USAA Cafeteria Plan, common examples of a Permissible Mid-Year Election Change include the following:

- A “Change in Status” (as defined in the Cafeteria Plan) which includes, for example, a change in your legal marital status, a change in the number of your dependents, your dependent first becoming or ceasing to be eligible for coverage under a benefit program due to attainment of age or other applicable circumstance, or a change in the employment status of you, your spouse, or your dependent. **NOTE: Even if a Change in Status occurs, you may not make a change in your elected coverage unless the change you request is on account of and corresponds with the Change in Status event.** This means that the change in coverage you are requesting must be justified by or needed because of the particular Change in Status event.

- A “special enrollment” event (within the meaning of applicable law) which, includes, for example, a participant acquiring a new Eligible Dependent through marriage, birth, or adoption, as well as if you or your Eligible Dependent (i) was not enrolled in the applicable benefit program upon initial eligibility or other enrollment opportunity because you or your Eligible Dependent was covered under another group health plan and (ii) had such coverage terminated due to loss of eligibility (other than by reason of failure to pay premiums) or cessation of employer contributions.

- Other Permissible Mid-Year Election Change events described in the Cafeteria Plan, which include, for example, if a judgment, decree, or order resulting from a divorce or change in legal custody (including a “qualified medical child support order”) requires accident or health coverage under the Plan for your child or dependent foster child.

Please see the summary plan description for the USAA Cafeteria Plan for more details about Permissible Mid-Year Election Change events.

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Timing of Permissible Mid-Year Election Changes

In order to make a mid-year change, the election change must be made within 31 days of the occurrence of the Permissible Mid-Year Election Change event (or within 60 days of the Permissible Mid-Year Election Change event for certain events, such as a birth, adoption, or placement for adoption). See the summary plan description for the Cafeteria Plan for more details on the required timing of a permissible mid-year election change.

NOTE: If you are entitled to make a Permissible Mid-Year Election Change but you do not make a change within the 31-day (or, if applicable, 60-day) window applicable to the Permissible Mid-Year Election Change event, you may not make any changes until the next annual enrollment period (with coverage effective on the following Annual Enrollment Date) unless another Permissible Mid-Year Election event occurs earlier that entitles you to make a mid-year change.

How to Make a Permissible Mid-Year Election Change

NOTE: It is important that you make a Permissible Mid-Year Election Change according to the required enrollment or change procedures. Failure to properly and timely make a Permissible Mid-Year Election Change may result in you (or your Eligible Dependent) not being covered under the benefit program.

You must add a new Eligible Dependent within the 31-day (or, if applicable, 60-day) period for the child to be covered, even if you already have coverage under a Family coverage category (i.e., You + Child(ren) or Family). Log on to the MyLife website to add a new dependent. If you have problems adding your new dependent online, or if you would like additional information about Permissible Mid-Year Election Change events, contact the USAA Benefits Center at 800-210-USAA.

Giving Notice of Changes in Your Family

You must promptly notify the USAA Benefits Center at 800-210-USAA or directly online at the MyLife website when the following changes in your family take place:

- You marry or divorce;
- A child is born, adopted, or involved in a placement for adoption;
- A child reaches age 26;
- A member of your family who is covered by the Plan dies; or
- You receive a court order to provide health coverage for your child.

These family changes may result in an individual no longer being eligible for coverage under the Dental Program. For example, when a child reaches the dependent age limit of 26 (the dependent age limit), he or she is no longer eligible for dependent coverage under the Dental Program. Similarly, coverage for your dependent spouse terminates upon divorce.

Benefits are not available for expenses incurred after termination of coverage. If your dependent’s coverage is terminated, contributions you paid, if any, will not be refunded for any period before the date of notification. In addition, if benefits are paid prior to notification to the Claims Administrator, you will be requested to refund those amounts.

Please refer to the separate summary plan description for the Wrap Plan for details regarding continuation of coverage for your former Eligible Dependent who is no longer eligible for coverage.

If you change your address, nonactive plan participants (e.g., LTD participants, COBRA participants, survivors, retirees, nonactive employees on military leave, etc.) must update that address with the USAA Benefits Center at 800-210-USAA. Active employees must update their address in Self Service on Connect.
How the Delta Dental PPO Option Works

The Delta Dental PPO benefit option offered under the Dental Program may result in an overall reduction in your dental care costs. The next several sections of this summary relate specifically to the coverage available under the Delta Dental PPO. For more detailed information on the Aetna DHMO option, please refer to the certificate of insurance booklet issued by Aetna.

Flexibility in Selection of Dentist under Delta Dental PPO

You may choose to go to any dentist under the Delta Dental PPO option. However, using a Delta Dental PPO Dentist ("PPO Dentist") allows you to reduce the cost of your out-of-pocket expenses. This select group of dentists will provide dental benefits at a charge that has been contractually agreed upon between Delta Dental and the PPO Dentist. The charges are generally lower than those charged by the majority of dentists in the same area. You are responsible for any co-insurance and for any amounts that exceed the maximums specified below.

Delta also offers you a choice of selecting a Delta Dental Premier® Dentist ("Premier Dentist"). Although the Premier Dentist has not agreed to the same contracted arrangement as the PPO Dentist described above, you may still receive dental care at a lower cost. The Premier Dentist has contractually agreed not to charge you any amount above the Maximum Plan Allowance ("MPA") (as defined below). However, you are still responsible for any deductibles and co-insurance and for any amounts that exceed the maximums specified below.

If a dentist is not a Premier Dentist or PPO Dentist, the amount charged to you may be above that charged by a Premier Dentist or PPO Dentist. When Delta Dental PPO pays benefits for services provided by a Non-Delta Dental Dentist ("Non-Delta Dentist"), benefits will be determined based on the Maximum Plan Allowance (as defined below). You will be responsible for any amount charged over the amount paid by Delta Dental. You are also responsible for any deductibles and co-insurance and for any amounts that exceed the maximums specified below. The Non-Delta Dentist will bill you for the balance after Delta’s payment is made.

Delta Dental’s directory of PPO Dentists is available on the Internet. Go to: Connect > Benefits & Wellness > MyLife > My Health > View Benefit Provider Contact List > Delta Dental (this is single sign-on access). The direct website is: http://www.deltadentalins.com/usaa/. The website also provides information about Premier Dentists. You are responsible for verifying whether the dentist you select is in the Delta Dental network.

Dentists are regularly added to the network, so it is a good idea to call the dental office to confirm whether they participate in the Delta Dental network.

Deductible

The deductible is the amount of eligible expenses you must pay each Plan Year before the Delta Dental PPO option pays for services by a Premier Dentist or a Non-Delta Dentist. (The deductible does not apply to services by a PPO Dentist.) The deductible applies to eligible Basic Restorative Services, Major Restorative Services, and Implant Services (see “What the Delta Dental PPO Option Covers” section). There is an individual deductible and a family deductible.

Individual Deductible

The individual deductible is $50. After you or a covered dependent have met the individual deductible, the Delta Dental PPO option pays benefits for that individual’s eligible expenses for the remainder of the Plan Year.
Family Deductible
The family deductible is $150. When the combined eligible expenses of all covered family members total $150 during a Plan Year (taking into account no more than $50 in eligible expenses for each family member), your family has met the family deductible. Only eligible expenses for each covered family member up to the individual deductible ($50) can be applied toward the family deductible. After the family deductible is met, benefits will then be paid for all covered family members for the remainder of the Plan Year, even if a covered family member has not met the individual deductible.

Covered Dental Care
The Delta Dental PPO option will pay benefits only for covered services. These services must be provided by a duly licensed dentist practicing within the scope of the dental profession or any other physician furnishing dental services which such physician is licensed to perform (a “Dentist”) and must be necessary and customary under generally accepted dental practice standards. Delta Dental may use dental consultants to review treatment plans, diagnostic materials, and/or prescribed treatments to determine generally accepted dental practices.

If you receive dental services from a Dentist outside the state of Texas, the Dentist will be reimbursed according to Delta Dental’s network payment provisions for that state according to the terms of the applicable contract.

If a comprehensive dental procedure includes component or interim procedures that are performed in conjunction with the comprehensive procedure, the component or interim procedures are considered to be part of the comprehensive procedure for purposes of determining the benefit payable under the Delta Dental PPO option. If the Dentist bills separately for the comprehensive procedure and each of its component or interim parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the comprehensive procedure.

Maximum Plan Allowance
The “Maximum Plan Allowance” or “MPA” means the maximum allowable amount determined by the Claims Administrator (Delta Dental) to be payable for a particular service, supply, or procedure. The Claims Administrator determines the MPA by taking into account factors it deems appropriate, which may include review of proprietary filed fee data and actual submitted claims from providers in the same geographical area with similar professional standing. The MPA may vary by the type of network dentist. The determination of whether expenses are within or exceed the MPA is the exclusive decision of the Claims Administrator.

Premier Dentists agree to charge you no more than the MPA amount approved by Delta Dental. (PPO Dentists agree to charge you no more than the PPO Fee Schedule.) If you receive services from a Non-Delta Dentist and the dental treatment expense is more than the MPA amount, you are responsible for the difference between the amount billed and the MPA approved by the Claims Administrator.

Co-Insurance
Co-insurance is a percentage of the Maximum Payment Amount (or, in the case of a PPO Dentist, a percentage of the PPO Fee Schedule amount) that is not paid or reimbursed by the Dental Program. After you satisfy the applicable deductible, you and USAA share the cost of additional expenses. As shown below, the co-insurance percentage is generally more favorable for a PPO Dentist than for a Premier Dentist or a Non-Delta Dentist. The co-insurance percentages for the various covered services are described below under “What the Delta Dental PPO Option Covers.”
**Dental Annual Maximum and Other Maximums**

The total amount of in-network benefits that may be paid each Plan Year for each Dental Program participant (including each covered dependent) is $1,500, which is the “Dental Annual Maximum.” The Dental Annual Maximum for out-of-network benefits is $1,000.

Implant Services are not subject to the Dental Annual Maximum, but are subject to the Implant Annual Maximum and the Implant Lifetime Maximum (as defined below under “Covered Implant Services”).

Orthodontic Services are not subject to the Dental Annual Maximum, but are subject to the Orthodontic Lifetime Maximum (as defined below under “Covered Orthodontic Services”).

All coverage under the Delta Dental PPO option (regardless of whether there is any intervening periods of non- participation or different coverage categories and regardless of whether covered as an employee, retiree, qualified beneficiary, and/or dependent) will be counted toward a person’s Implant Lifetime Maximum and Orthodontic Lifetime Maximum.

**Pre-Treatment Estimate**

The Delta Dental PPO option does not require a pre-treatment estimate prior to services being performed. **However, the Delta Dental PPO strongly recommends pre-treatment estimates if your expenses are over $300.** Pre-treatment estimates are a good tool to use to determine your out-of-pocket-expenses, and are valid for a period of 60 days from the date of the estimate (but expire at the contract’s term or the date the patient’s coverage ends).

Delta Dental has the right to request a narrative with the claim explaining the necessity for services if the service appears questionable or cosmetic in nature.

For additional information regarding specialized care, you should contact Delta Dental.

PUBLIC INFORMATION:
May be discussed or shared with non-USAA employees.
### Summary Chart of Benefits for Delta Dental PPO Option

<table>
<thead>
<tr>
<th></th>
<th>Delta PPO Dentist (Benefit based on Fee Schedule)</th>
<th>Delta Premier Dentist (Benefit paid based on MPA)</th>
<th>Non-Delta Dentist (Benefit paid based on MPA)</th>
</tr>
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<tbody>
<tr>
<td>Who's Covered?</td>
<td>Eligible employees/retirees, Spouses, Domestic Partners and dependent children to age 26</td>
<td>Dentist will not balance bill</td>
<td>Dentist can balance bill</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>$1,500</td>
<td>$1,500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$0</td>
<td>$50 / Individual $150 / Family</td>
<td>$50 / Individual $150 / Family</td>
</tr>
<tr>
<td>Diagnostic and Preventive: Oral exam, cleanings, x-rays, fluoride, sealants, space maintainers</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Restorative Services: Extractions, restorative services, denture repairs, root canals, gum treatments</td>
<td>90%*</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Major Restorative Services: Crowns, inlays, onlays and cast restorations, bridges, partial dentures, full dentures, denture repairs</td>
<td>80%</td>
<td>70%</td>
<td>40%</td>
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<tr>
<td>Orthodontic Services</td>
<td>80%</td>
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<tr>
<td>Orthodontic Lifetime Maximum</td>
<td></td>
<td>$1,500 / Individual</td>
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<tr>
<td>Implant Services</td>
<td>80%</td>
<td>70%</td>
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<tr>
<td>Implant Maximums</td>
<td>$1,500 Annual</td>
<td>$5,000 Lifetime</td>
<td></td>
</tr>
</tbody>
</table>

**MPA:** Maximum allowable amount determined by Delta Dental to be payable for a particular services, supply or procedure.

* Ceramic porcelain restorations on posterior teeth are covered at 80%, whether In-Network or Out-of Network. **Note:** If a specific dental condition can be treated by two or more different services according to customary dental practice, the Delta Dental PPO option may consider a charge to have been incurred for the least costly of such services which would have produced a professionally satisfactory result.
What the Delta Dental PPO Option Covers

Subject to the other terms and limitations in the Dental Program, expenses that are covered by the Delta Dental PPO option include the following:

**Covered Diagnostic and Preventive Services**

The Delta Dental PPO pays:

- 100% of the PPO Fee Schedule for Diagnostic and Preventive Services received from a PPO Dentist.
- 100% of the MPA for Diagnostic and Preventive Services received from a Premier Dentist.
- 100% of the MPA for Diagnostic and Preventive Services received from a Non-Delta Dentist. The deductible does not apply to Diagnostic and Preventive Services.

“**Diagnostic and Preventive Services**” include:

**Diagnostic:** Procedures to assist the dentist in choosing required dental treatment.

**Preventive:**

1. Oral examinations;
2. X-rays;
3. Prophylaxis (cleaning)
   - Periodontal cleaning in the presence of inflamed gums is considered to be Basic Restorative Services (and not Diagnostic and Preventive Services) for purposes of the benefit payment provisions;
4. Topical application of fluoride solutions; and
5. Sealants.

**Limitations on Diagnostic and Preventive Services**

1. Routine oral examinations and cleanings (including periodontal cleanings) are limited to two (2) times in any Plan Year.
   
   Note that periodontal cleanings are covered as Basic Restorative Services, and regular cleanings are covered as Diagnostic and Preventive Services.

2. X-rays
   a. Bite-wing X-rays are limited to two (2) per Plan Year; and
   b. Full mouth x-rays or panographic x-rays are limited to once every three (3) years.

3. Fluoride treatment is limited to two (2) per Plan Year.

4. Sealants
   a. Limited to application to permanent molars with no caries (decay), without restorations and with the occlusal surface intact; and
   b. Benefits do not include the repair or replacement of a sealant on any tooth within two (2) years of its application.

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Covered Basic Restorative Services

The Delta Dental PPO pays:

- 90% of the PPO Fee Schedule for Basic Restorative Services received from a PPO Dentist, except that the Delta Dental PPO pays 80% of the PPO Fee Schedule in the case of ceramic porcelain restorations on posterior teeth.
- 80% of the MPA for Basic Restorative Services received from a Premier Dentist.
- 60% of the MPA for Basic Restorative Services received from a Non-Delta Dentist.

The deductible applies to Basic Restorative Services received from a Premier Dentist or a Non-Delta Dentist.

“Basic Restorative Services” include:

Oral Surgery: Simple extractions, including pre- and post-operative care.

Anesthesia: When administered by a Dentist for a covered oral surgery procedure.

Endodontics: Treatment of the tooth pulp.

Periodontics: Treatment of the gums and the bones supporting teeth.

Palliative: Treatment to relieve pain.

Space Maintainers: An appliance used to maintain space in the mouth when the deciduous teeth are lost early.

Restorations: Amalgam, synthetic porcelain, plastic fillings, and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure).

Limitations on Basic Restorative Services

1. Routine oral examinations and cleanings (including periodontal cleanings) are limited to two (2) times in any Plan Year.

   *Note that periodontal cleanings are covered as Basic Restorative Services, and regular cleanings are covered as Diagnostic and Preventive Services.*

2. Perioscaling and root planning per quadrant (limited to once in every 24 month period) will be considered Basic Restorative Services.

   - Gingivectomy or gingivoplasty-per quadrant, gingivectomy or gingivoplasty per tooth, gingival curettage-surgical – per quadrant by report, gingival flap procedure-including root planning – per quadrant are considered Major Restorative Services.

3. The Delta Dental PPO option will not pay to replace an amalgam, synthetic porcelain, or plastic restorations (fillings) or prefabricated stainless steel restorations within 24 months of treatment if the service is provided by the same dentist.

4. Ceramic porcelain restorations on posterior teeth are covered at 80%, whether In-Network or Out-of- Network.

PUBLIC INFORMATION:
May be discussed or shared with non-USAA employees.
Covered Major Restorative Services

The Delta Dental PPO option pays:

- 80% of the PPO Fee Schedule for Major Restorative Services received from a PPO Dentist.
- 70% of the MPA for Major Restorative Services received from a Premier Dentist.
- 40% of the MPA for Major Restorative Services received from a Non-Delta Dentist.

The deductible applies to Major Restorative Services received from a Premier Dentist or a Non-Delta Dentist.

“Major Restorative Services” include:

Denture Repairs: Repair to partial or complete dentures including re-base procedures and relining.

Crowns, Inlays, Onlays, and Cast Restorations (including prefabricated stainless steel): For treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, or plastic restorations.

Prosthodontic Benefits: Procedures to construct or repair fixed bridges and construction of partial or complete dentures.

MPD-TMJ Benefits: Intra-oral services provided by a licensed Dentist, when necessary and customary according to the standards of generally accepted dental practice, for treatment of acute dental symptoms associated with myofacial pain dysfunction (MPD) or malfunction of the temporomandibular (jaw) joint (TMJ).

Limitations on Major Restorative Services

1. Delta Dental PPO will not pay to replace any bridge, denture or appliance that the patient received in the previous five years, unless the restorative service is necessary to make the bridge or denture satisfactory due to a change in supporting tissues or because too many teeth have been lost, or if a denture is lost or broken.

2. Delta Dental PPO will not pay to replace any crown, inlay, onlay, or cast restoration that the patient received in the previous five years. An exception may be made based on dental consultant review.

3. Delta Dental PPO limits payment for dentures to a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.

4. MPD-TMJ benefits are subject to all the limitations, exclusions, definitions and other terms of the Dental Program.

5. Delta Dental PPO will not pay for the repair or replacement of any MPD-TMJ appliance furnished in whole or part under the Dental Program or any other health program that provides MPD-TMJ benefits.

6. Benefits are limited to those intra-oral services which would normally be provided by a licensed Dentist in relief of oral symptoms associated with MPD-TMJ and do not include those services which would normally be provided under medical care including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.

7. Any procedure paid under any other category of benefits by the Dental Program is not covered as an MPD-TMJ benefit.

PUBLIC INFORMATION:
May be discussed or shared with non-USAA employees.
Covered Orthodontic Services

The Delta Dental PPO option pays:

- 80% of the PPO Fee Schedule for Orthodontic Services provided by a PPO Dentist.
- 80% of the MPA for Orthodontic Services provided by a Premier Dentist.
- 40% of the MPA for Orthodontic Services provided by a Non-Delta Dentist.

The deductible does not apply to Orthodontic Services. In addition, Orthodontic Services are not subject to the Dental Annual Maximum (see “How the Delta Dental PPO Option Works”). However, Orthodontic Services are subject to the Orthodontic Lifetime Maximum (defined below under “Limitations on Orthodontic Services”).

“Orthodontic Services” is a dental service performed by a Dentist involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of mal-alignment of teeth and/or jaws that significantly interferes with their functions. Orthodontic Services include:

- Appliances;
- Braces; and
- Retainers.

Limitations on Orthodontic Services

1. The Delta Dental PPO requires all current and future Orthodontic patients to submit a treatment plan to the Claims Administrator, in the time and manner required by the Claims Administrator. Your dentist may contact Delta Dental for procedures on how to submit the treatment plan. The Delta Dental PPO option will not cover Orthodontic Services for which a full and complete treatment plan has not been timely submitted.

2. The maximum amount of benefits that will be paid for Orthodontic Services for each Dental Program participant (including each covered dependent) during the participant's lifetime is $1,500 (the “Orthodontic Lifetime Maximum”).

3. All benefit payments will be on a monthly basis.

4. Any obligation to make periodic payments for Orthodontic Services will terminate on the payment due date next following the date your covered dependent or you loses coverage, or upon termination of the Delta Dental PPO option, whichever occurs first.

5. Benefits are not paid to repair, replace or adjust Major Restorative Services or Implant Services furnished within five years, in whole or in part, under this Dental Program.

6. X-rays or extractions are not subject to the Orthodontic Lifetime Maximum.

7. Surgical procedures are not subject to the Orthodontic Lifetime Maximum.

PUBLIC INFORMATION:
May be discussed or shared with non-USAA employees.
**Covered Implant Services**

The Delta Dental PPO pays:

- 80% of the PPO Fee Schedule for Implant Services received from a PPO Dentist.
- 70% of the MPA for Implant Services received from a Premier Dentist.
- 40% of the MPA for Implant Services received from a Non-Delta Dentist.

The deductible applies to Implant Services received from a Premier Dentist or a Non-Delta Dentist.

Implant Services are not subject to the Dental Annual Maximum (see “How the Delta Dental PPO Option Works”), but are subject to the Implant Annual Maximum and the Implant Lifetime Maximum (defined below under “Limitations on Implant Services”).

“Implant Services” include procedures performed by a Dentist for the following: endosseous, transosseous, subperiosteal and endodontic implants; implant connecting bars and implant repairs. Implants are defined as prosthetic appliances placed into or on bone of the maxilla or mandible (upper or lower jaw) to retain or support dental prosthesis. The Delta Dental PPO covers only implants approved by the American Dental Association. Implant Services include:

- Surgery;
- Anesthesia;
- Implant hardware; and
- Implant replacement.

**Limitations on Implant Services**

1. The maximum amount of benefits that will be paid each Plan Year for Implant Services for each Dental Program participant (including each covered dependent) is $1,500 (the “**Implant Annual Maximum**”).

2. The maximum amount of benefits that will be paid for Implant Services for each Dental Program participant (including each covered dependent) during the participant’s lifetime is $5,000 (the “**Implant Lifetime Maximum**”).

3. Delta Dental PPO will not pay to replace any implant that the patient received in the previous five (5) years.

4. Benefits are not payable for the removal of any implants.

5. Prosthodontic devices and procedures associated with, but not included within, the definition of “Implants” are not subject to the Implant Annual Maximum or the Implant Lifetime Maximum.
   a. Such prosthetic devices include crowns, dentures, fixed bridges and partial dentures.
   b. Related procedures include IV sedation.
   c. These prosthetic devices and procedures are covered when provided at the time of Implant Services; however, they will be considered Major Restorative Services and subject to the Dental Annual Maximum (but not the Implant Annual Maximum or Implant Lifetime Maximum).

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What the Dental Program Does Not Cover

Certain dental expenses are not covered by the Dental Program. They include:

1. Charges that are more than the Maximum Plan Allowance (or MPA) for a Premier Dentist and Non- Delta Dentist;

2. Charges for dental services that are not considered necessary treatment (Note: X-rays, narratives from the dentist, reviews by a dental consultant, and other materials or opinions may be used by the Claims Administrator in determining necessary services);

3. Cosmetic procedures;

4. Charges you are not legally obligated to pay or that are made only because you have dental coverage;

5. Services for injuries or conditions which are compensable under workers’ compensation or Employers’ liability laws;

6. Services which are provided to you and your covered dependents by any federal, state or local agency, unless and to the extent this exclusion is prohibited by law;

7. Charges related to treatment for an accident or injury covered under a group medical plan (including the USAA Medical Care Program);

8. Charges for completion or copies of forms, records, or related materials;

9. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration) of the teeth, and anodontia (congenitally missing teeth), except those services provided to newborn children for congenital defect or birth abnormalities, services that may be provided under Orthodontic Services, or cosmetic services due to accidental injury sustained while the person was a covered individual;

10. Orthodontic appliances that were installed before an individual’s coverage under the Delta Dental PPO option became effective (unless you submit documentation acceptable to Delta Dental that such orthodontic appliances were installed while the patient was covered under the Aetna DHMO option of the Dental Program);

11. All orthognathic surgical procedures performed by oral surgeons;

12. Charges for personalization or characterization of dentures;

13. Charges for education or training in and supplies used for personal hygiene or dental plaque control;

14. Prescribed drugs, medication, or analgesia;

15. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility;

16. Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services;

17. An appliance where an impression was made before the individual became covered under the Delta Dental PPO;

18. A crown, bridge or restoration if the tooth was prepared before the individual became covered under the Delta Dental PPO;

19. Root canal therapy if the pulp chamber was opened before the individual became covered under the Delta Dental PPO;

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20. Charges for infection control;
21. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues);
22. Services performed by any person other than a Dentist or auxiliary personnel legally authorized to perform services under the direct supervision of a Dentist;
23. Treatment rendered by a person who ordinarily resides in the Dental Program participant’s household or who is related to the participant (or to the participant’s Spouse) by blood, marriage or legal adoption; or
24. Services for restoring tooth structure lost from wear, erosion, or abrasion, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to equilibration, periodontal splinting, and occlusal adjustment.

Claims

Filing Deadline
All Delta Dental PPO option dental claims must be submitted no later than the following deadline:

<table>
<thead>
<tr>
<th>Type of Initial Claim</th>
<th>Filing Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delta Dental PPO option</td>
<td>12 months after the date of service</td>
</tr>
<tr>
<td>Aetna DHMO option</td>
<td>See separate summary booklet for Aetna DHMO</td>
</tr>
</tbody>
</table>

Claims submitted after the deadline will be denied unless the Claims Administrator determines, based on information submitted by you or the provider, that the delay could not have been avoided by reasonable actions on your part or the part of the provider. Claims for benefits must be submitted to the appropriate Claims Administrator for the option in which you are enrolled.

Claim Forms
You should direct claims for benefits under the Dental Program to the appropriate Claims Administrator listed below under “Plan Administrator and Claims Administrators” and must provide any information required by the Claims Administrator in order to process your claim. For filing claims with respect to Delta Dental PPO see the section below entitled “Applying for Delta Dental PPO Benefits.” For filing claims with respect to the Aetna DHMO option, see the certificate of insurance booklet issued by Aetna. In general, a casual inquiry regarding whether an expense is covered under the Plan will not be treated as a claim for benefits under the Plan.

The Plan Administrator or Claims Administrator, at its own expense, shall have the right and opportunity to examine the participant (or dependent) when and as often as it may be reasonably required during the pendency of a claim. Disputed claims should be referred directly to the appropriate Claims Administrator.

PUBLIC INFORMATION:
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Applying for Delta Dental PPO Benefits

Claims for Delta Dental PPO benefits must be filed on a standard Attending Dentist Statement that you or your dentist may obtain from:

**Delta Dental Insurance Company**  
P.O. Box 1809  
Alpharetta, GA 30023  
(800) 521-2651

Delta Dental claim forms are available from the Delta Dental PPO’s website. Go to: Connect > Benefits & Wellness > MyLife > My Health > View Benefit Provider Contact List > Delta Dental (this is single sign-on access). The direct website is: [http://www.deltadentalins.com/usaa/](http://www.deltadentalins.com/usaa/) or by calling Delta Dental at 1-800-873-1051. Customer Service is available from 6:15 a.m. through 6:30 p.m. (CST).

**Claims/Appeals Procedures**

All claims under the Dental Program must be made in writing by you or the provider and will be determined in accordance with the claims procedures described in the **USAA Group Health Care Arrangement Summary Plan Description** booklet. Your rights to appeal the denial of a claim (including the deadlines for making such an appeal) are also described in the summary plan description for the Wrap Plan.

**Claims for Aetna DHMO Benefits**

For purposes of determinations of the amount of, or entitlement to, benefits under options provided through the Aetna DHMO or insurance contracts, the respective DHMO is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan and/or contract as they relate to benefits provided under the applicable DHMO contract.

To obtain benefits from the DHMO, you must follow the claims procedures under the applicable DHMO contract or booklet. The DHMO will decide your claim in accordance with its reasonable claims procedure, as required by ERISA. The DHMO has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the DHMO denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial. If your claim is denied, you may appeal to the DHMO for a review of the denied claim. The DHMO will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. See the DHMO booklet for more information about how to file a claim and for details regarding the DHMO’s claim procedures.

**Payment of Claims for Delta Dental PPO**

Delta Dental PPO Dentists and Premier Dentists shall be paid directly. Any other payments provided by the Delta Dental PPO will be made to you, unless you request when filing a claim that the payment be made directly to the dentist providing the services. All benefits not paid to the dentist shall be payable to you, or to your estate, except if the person is a minor or otherwise not competent to give a valid release (in which case, benefits may be payable to the person’s parent or guardian).

The Claims Administrator reserves the right to request any information required to determine benefits or process a claim. You or the provider of services will be contacted if additional information is needed to process your claim.

**Overpaid Benefits**

If a benefit is overpaid, the Claims Administrator has the right to recover the excess amount from the party who received the payment or from the Dental Program participant. The Claims Administrator can reduce any future benefit payments to make up for the overpayment.

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**Unclaimed Benefit Payments**

Any benefit payments that are unclaimed (e.g., uncashed benefit checks) by the last day of the Plan Year following the Plan Year in which the applicable expense was incurred will be forfeited, and a participant will have no right to receive payment or re-issuance of the forfeited amounts.

**Coordination of Benefits (COB)**

The purpose of coordinating benefits is to avoid duplication of benefit payments. This means that the total reimbursement from all group plans will not be more than the actual charges (up to the allowable amount charge limits). Refer to the **USAA Group Health Care Arrangement Summary Plan Description** booklet for a more detailed discussion of the coordination of benefit rules applicable to the Dental Program.

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**When Coverage Ends**

**When Your Coverage Ends**

Your coverage under the Dental Program ends on the earliest to occur of the following events:

- The date you terminate employment with USAA or a Participating Employer. However, if you are determined to be disabled under the USAA Long-Term Disability (LTD) Benefit Program by the appointed fiduciary of that program, your coverage under the Dental Program may continue even though your employment ends. In addition, certain Retirees may be immediately eligible for coverage under the Dental Program as a Retiree. See the separate summary booklet entitled “Upon Retirement” for more information.
- The date you cease to be an Eligible Employee due to a change in employment status;
- The date you begin a leave of absence, except for certain approved leaves (including leaves under the Family and Medical Leave Act);
- The date of your death;
- The first day of the period for which you fail to make, within the required time period, any required contribution to the Dental Program;
- The Annual Enrollment Date for which you elect to drop your coverage under the Dental Program;
- The effective date you drop your coverage under the Dental Program consistent with a Permissible Mid-Year Election Change event (see “Changing Coverage and Benefit Elections” section); or
- The effective date of termination of the Dental Program.

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When Coverage of Your Enrolled Eligible Dependent Ends

Coverage of your Eligible Dependent under the Dental Program ends on the earliest to occur of the following events:

- The date your Eligible Dependent ceases to be an Eligible Dependent. However, if a dependent child attains age 26* and is permanently disabled, incapable of self-support, dependent on you for support, and covered under the Dental Program when he or she turns age 26 (and is otherwise an Eligible Dependent), coverage may continue under this Program if you provide satisfactory proof of the disability within 31 days after the dependent’s 26th* birthday. You will be required to provide proof of disability annually.

* In the case of the Aetna DHMO option for an employee living in Texas, the age limit for an Eligible Child is under age 26. See the separate summary booklet applicable to your state for more details about dependent eligibility for the Aetna DHMO option.

- The first day of the period for which you fail to make, within the required time period, any required contribution to the Dental Program;

- The Annual Enrollment Date for which you elect to terminate your Eligible Dependent’s coverage under the Dental Program;

- The effective date you drop your Eligible Dependent’s coverage under the Dental Program consistent with a Permissible Mid-Year Election Change (see “Changing Coverage and Benefit Elections” section); or

- The effective date of termination of the Dental Program.

Note: Your dependents normally cease to be Eligible Dependents on the date you cease to be eligible for the Dental Program. However, if you die while covered under the Dental Program, then any of your Eligible Dependents who are covered under the Dental Program at the time of your death will be eligible to continue coverage (provided the dependents waive COBRA coverage) until the earliest to occur of (1) the events listed above in this section determined as if your death had not occurred (for example, a dependent child attaining age 26), (2) the date the Eligible Dependent becomes eligible for coverage under any other dental plan, (3) the date the Eligible Dependent voluntarily discontinues coverage, or (4) with respect to your surviving Spouse only, the remarriage of your surviving Spouse.

If a dependent covered under the Dental Program at the time of your death does not elect coverage or subsequently drops coverage under the Dental Program, this individual will become permanently ineligible to participate in the Dental Program as your dependent.
Treatment in Progress

Generally, there is no coverage under the Dental Program for any services received after your coverage ends, even if services are part of a treatment program that began before coverage ended. However, the Delta Dental PPO option will pay for a single procedure (that is, a dental procedure that is assigned a separate CDT number) that was incurred when the patient was covered under the Delta Dental PPO option if such procedure is completed within 31 days of the date coverage ends.

A single procedure is considered to be incurred at the following time:

- For an appliance (or change to an appliance), at the time the impression is made;
- For a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- For root canal therapy, at the time the pulp chamber is opened; and
- For all other dental services, at the time the service is performed or the supply furnished.

COBRA Continuation of Coverage

Upon termination of coverage of you or your Eligible Dependent, continuation of coverage under the Dental Program may be available for a limited period of time under COBRA. Please refer to the separate summary plan description for the Wrap Plan for important information about your rights and responsibilities under COBRA. An eligible same-sex Spouse (and his or her Eligible Dependents) are entitled to continuation of coverage, subject to same terms and limitations that apply under COBRA.

Eligible employees who are offered and accept severance pay under a USAA severance plan or agreement may receive additional COBRA benefits. Please refer to your severance agreement and the separate summary plan description for the USAA Severance Plans for a description of these benefits.

Converting Coverage

Dental Program coverage cannot be converted from group insurance to an individual USAA policy.

Amendment and Termination of Dental Program

Amendment of Program

The Dental Program may be amended in whole or in part by USAA in its absolute discretion at any time and from time to time, for any or no reason. In addition, the Plan Administrator may amend the Program in its discretion in certain specified circumstances.

Termination of Program

The Dental Program may be terminated by USAA in its absolute discretion at any time and from time to time, for any or no reason.

If the Program Is Modified or Terminated

If the Dental Program ever is terminated, suspended, or modified, benefits for services received before the change would be paid under the Program’s former terms and conditions, but no benefits would be paid for services received after the date such action becomes effective, unless specific provisions are adopted.

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Administration of Dental Program

The Dental Program is a component benefit of the USAA Group Health Care Arrangement (the “Wrap Plan”). The Executive Vice President of Human Resources has been appointed as Plan Administrator of the Wrap Plan, and has been given the authority to further delegate the role of Plan Administrator by appointing others to serve in that capacity. Please refer to the USAA Group Health Care Arrangement Summary Plan Description booklet for more information about the powers and duties of the Plan Administrator. A list of the Claims Administrators for the Dental Program is located under “Plan Administrator and Claims Administrators.”

Other Important Information

Other important information about the Dental Program can be found in the USAA Group Health Care Arrangement Summary Plan Description booklet. You may obtain a copy of most current version of any summary plan description booklet by visiting the MyLife website or by contacting the USAA Benefits Center at 800-210-USAA.

Plan Administrator and Claims Administrators

Plan Administrator of USAA Group Health Care Arrangement

Executive Vice President, People Services
USAA
9800 Fredericksburg Road
San Antonio, TX 78288
800-210-USAA

Claims Administrators for Dental Program, Delta Dental PPO

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809
800-521-2651

Aetna DHMO

<table>
<thead>
<tr>
<th>Aetna DHMO Claims Administrator</th>
<th>For These States…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna U.S. Healthcare P.O. Box 12323 Albany, NY 12212-2323</td>
<td>ME, NH, NY, CT, RI, NJ, PA, MA, OH, WV, VA, MD, MI, IN, KY, TN, NC, WI, IL, DE, SC</td>
</tr>
<tr>
<td>Aetna U.S. Healthcare Complaints/Appeals Dental CRT P.O. Box 14597 Lexington, KY 40512</td>
<td>TX, AR, LA, MS, AL, GA, FL</td>
</tr>
<tr>
<td>Aetna U.S. Healthcare P.O. Box 10412 Van Nuys, CA 91410</td>
<td>WA, OR, CA, ID, NV, MT, WY, UT, AZ, ND, SD, NE, CO, NM, KS, OK, MN, IA, MO</td>
</tr>
</tbody>
</table>

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