

AMENDMENT #2

**To Plan Document Dated September 1, 2002
and Restated September 1, 2005**

**SOUTH TEXAS HEALTH COOPERATIVE
EMPLOYEE DENTAL BENEFIT PLAN**

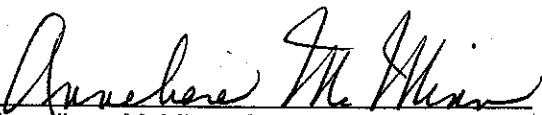
The following changes to the Plan Document are effective October 1, 2007:

1. All references in the Plan Document to Claims Administrator's address are deleted in their entirety and replaced as follows:

Group & Pension Administrators, Inc.
Park Central 8
12770 Merit Drive, 2nd Floor
Dallas, Texas 75251
972-238-7900 • 800-827-7223
2. Schedule of Dental and Orthodontic Benefits, page 7, is deleted in its entirety and replaced with the attached revised page 7.
3. Subrogation and Reimbursement Provisions, pages 26, 27 and 28, are deleted in their entirety and replaced with the attached revised pages 26, 27 and 28.
4. Annual Open Enrollment Period for the Employee Dental Benefit Plan, page 44, is deleted in its entirety and replaced with the attached revised page 44.
5. Benefit Changes, page 45, is deleted from the Plan Document in its entirety.

In all other respects, the Plan Document remains unchanged.

Acknowledged by:


Anneliese McMinn, Co-op Board President
South Texas Health Cooperative


Kathy Enchs, Chief Operating Officer
Group & Pension Administrators, Inc.

Date: _____

Date: 4-30-08

SCHEDULE OF DENTAL AND ORTHODONTIC BENEFITS

DENTAL PLAN I

(Dental Plan I is available to Employees of Rio Hondo ISD and LaFeria ISD)

Dental and Orthodontic Expense Benefits are separate from and in addition to the Medical Expense Benefits of this Plan. These benefits are available only if elected by an Eligible Employee for him/herself and Eligible Dependents.

MAXIMUM DENTAL BENEFIT	<u>Benefit</u>
Calendar Year Maximum Dental Benefit (Preventive, Basic and Major Services) Per Covered Person	\$1,000
Calendar Year Maximum Orthodontic Benefit Per Covered Dependent Child	\$500
Lifetime Maximum Orthodontic Benefit Per Covered Dependent Child	\$1,000
DENTAL CALENDAR YEAR DEDUCTIBLE	
Per Covered Person	\$50
Family Member Limit	3 Family members
BENEFIT PERCENTAGE	
Preventive Dental Services	100%; Deductible waived
Basic Dental Services	80% after Deductible
Major Dental Services	50% after Deductible
Orthodontic Services Benefits limited to Dependent Children under age 19	50%; Deductible waived

SUBROGATION AND REIMBURSEMENT PROVISIONS

PAYMENT CONDITION

1. The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").
2. A Covered Person(s), his/her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or his/her attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any third party or Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

SUBROGATION

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized.
2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any coverage and/or party causing the sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Covered Person(s) fails to file a claim or pursue damages against:
 - a. the responsible party, its insurer, or any other source on behalf of that party;
 - b. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c. any policy of insurance from any insurance company or guarantor of a third party;
 - d. Workers' Compensation or other liability insurance company; or
 - e. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

then the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s) and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

EXCESS INSURANCE

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

- a. the responsible party, its insurer, or any other source on behalf of that party;
- b. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c. any policy of insurance from any insurance company or guarantor of a third party;
- d. Workers' Compensation or other liability insurance company; or
- e. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH CLAIMS

In the event that the Covered Person(s) dies as a result of his/her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

OBLIGATIONS

1. It is the Covered Person(s) obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a. to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - b. to provide the Plan with pertinent information regarding the sickness, disease, disability or Injury, including accident reports, settlement information and any other requested additional information;
 - c. to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d. to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e. to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f. to not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person(s) may have against any responsible party or Coverage.
2. If the Covered Person(s) and/or his/her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).
3. The Plan's right to reimbursement and/or subrogation are in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

OFFSET

Failure by the Covered Person(s) and/or his/her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his/her obligation.

MINOR STATUS

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his/her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ANNUAL OPEN ENROLLMENT PERIOD FOR THE EMPLOYEE DENTAL BENEFIT PLAN

The Annual Open Enrollment Period for the Plan is the month of August of each year for coverage to become effective September 1, provided written application for coverage is made on or before the end of the Open Enrollment Period or within thirty-one (31) days after the Annual Open Enrollment Period. All Eligible Employees and Dependents not currently enrolled in the Plan may do so during the Annual Open Enrollment Period. Re-enrollment for Covered Employees is not required unless a Covered Employee requests a coverage change or a Plan Option change.

LATE ENROLLEE

A Late Enrollee is an Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan. A Late Enrollee can only enroll once a year during the Annual Open Enrollment Period for the Plan unless the person qualifies for a Special Enrollment or if there is a Status Change.

EMPLOYEE LATE ENROLLEE

An Employee is considered a Late Enrollee if:

1. He/she makes written application for coverage under the Plan more than thirty-one (31) days after the date of his/her initial eligibility;
2. He/she was not eligible for a Special Enrollment; or
3. He/she failed to enroll by the end of a Special Enrollment Period.

Effective Date of Coverage for Employee Late Enrollees

The effective date of coverage for an Employee who is a Late Enrollee will be the effective date of the next Annual Open Enrollment for the Plan.

DEPENDENT LATE ENROLLEE

A Dependent is considered a Late Enrollee if:

1. The Covered Employee makes written application for Dependent coverage after the thirty-one (31) day period immediately following his/her effective date of coverage and the Dependent was not enrolled by the end of a Special Enrollment Period;
2. The Covered Employee makes written request to add a Dependent after the thirty-one (31) day period immediately following the date of birth, date of marriage, date of adoption or date of Placement for Adoption; or
3. An Eligible Employee (not currently enrolled in the Plan) makes written request to add a new Dependent more than thirty-one (31) days after the Dependent's date of birth, date of marriage, date of adoption or date of Placement for Adoption.

Effective Date of Coverage for Dependent Late Enrollees

The effective date of coverage for each Dependent who is a Late Enrollee will be the effective date of the next Annual Open Enrollment for the Plan.

The Eligibility and Effective Date provisions are subject to the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as they may be amended.