COMPANION LIFE INSURANCE COMPANY
SCHEDULE FOR EXCESS LOSS INSURANCE

1. Contract Number: CLI 51,007
2. Contractholder: Edinburg Consolidated Independent School District
3. Address: 411 North 8th Avenue

   City: Edinburg State: TX Zip Code: 78541
4. Subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) to be included (list legal name and addresses):

   _____
   _____
   _____
5. Name and address of Designated Administrator:

   Blue Cross Blue Shield of Texas - 17806 IH 10 West Ste 200, San Antonio, TX 78257
6. Effective Date: January 1, 2022
7. Estimated Initial Enrollment (will be used as the Number of Covered Units during the first Contract Month):

Employee Only	2,885
Family	1,223

8. **GENERAL SCHEDULE OPTIONS:**

(a) Contract Period: 01/01/2022 to: 12/31/2022

(b) Disabled Persons [X] are [ ] are not covered.
Retired Employees [ ] are [X] are not covered.

(c) Aggregate Benefit [ ] Yes [X] No

Aggregate Contract Basis: Employee Benefit Plan Expenses must be:
Incurred from: N/A through N/A, and
Paid from: N/A through N/A.
Claims Incurred prior to the Contract Effective Date are limited to N/A.

Aggregate Eligible Claim Payments include: [ ] Medical [ ] Prescription Drugs
[ ] Dental Care [ ] Weekly (Disability) Income
[ ] Vision Care [ ] Other

Aggregate Monthly Factor per Covered Person:

Employee Only	N/A
Family	N/A

Aggregate Payable Percentage (excess of Deductible):	N/A
Maximum Eligible Claim Expense Per Covered Person:	N/A
Minimum Aggregate Deductible:	N/A
Maximum Aggregate Benefit (excess of Deductible):	N/A

Monthly Aggregate Accommodation [ ] Yes [X] No

Aggregate Terminal Liability [ ] Yes [X] No

(d) Specific Benefit [X] Yes [ ] No

Specific Contract Basis: Employee Benefit Plan expenses must be:
Incurred from: 01/01/2022 through 12/31/2022.
Paid from: 01/01/2022 through 03/31/2023.
Claims Incurred prior to the Contract Effective Date are Limited to: N/A

Specific Eligible Claim Payments include: [X] Medical [X] Prescription Drugs
[ ] Dental Care [ ] Weekly (Disability) Income
[ ] Vision Care [ ] Other

Specific Deductible (per Covered Person):	$350,000
Specific Deductible for the following Covered Person(s) will apply: N/A	N/A
Aggregating Specific Deductible	[X] Yes [ ] No
Aggregating Specific Deductible	$165,000
Specific Payable Percentage (excess of Deductible):	100%
Maximum Specific Benefit (per Covered Person in excess of Specific Deductible):	Unlimited

(e) Simultaneous Specific Reimbursement [X] Yes [ ] No

9. **PREMIUMS:**

(a) Aggregate Premium

Composite N/A

Total Minimum Annual Aggregate Premium N/A

Monthly Aggregate Accommodation

Composite N/A

Annual Premium in Advance: N/A

Aggregate Terminal Liability

Composite N/A

Annual Premium in Advance: N/A

(b) Specific Premium Per Month

Employee Only	$12.74
Family	$39.83

Specific Terminal Liability

Employee Only	N/A
Family	N/A

Minimum Monthly Specific Premium: N/A

10. **SPECIAL RISK LIMITATIONS:**

Contract will be based upon the current Employee benefits as defined in the Employee Benefit Plan by reference or by attachment, except as noted below:

Specific: _____

Aggregate: _____