

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**ADDITIONAL INSURED – DESIGNATED
PERSON OR ORGANIZATION**

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

<p>Name Of Additional Insured Person(s) Or Organization(s): Mt Diablo Unified School District</p>
<p>Information required to complete this Schedule, if not shown above, will be shown in the Declarations.</p>

A. Section II – Who Is An Insured is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by your acts or omissions or the acts or omissions of those acting on your behalf:

1. In the performance of your ongoing operations; or
2. In connection with your premises owned by or rented to you.

However:

1. The insurance afforded to such additional insured only applies to the extent permitted by law; and
2. If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

B. With respect to the insurance afforded to these additional insureds, the following is added to **Section III – Limits Of Insurance:**

If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement; or
 2. Available under the applicable Limits of Insurance shown in the Declarations;
- whichever is less.

This endorsement shall not increase the applicable Limits of Insurance shown in the Declarations.

POLICY NUMBER: PHUB756257



A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
 Bala Cynwyd, Pennsylvania 19004
 610.617.7900 Fax 610.617.7940
 PHLI.com

COMMERCIAL UMBRELLA LIABILITY INSURANCE POLICY DECLARATIONS

Philadelphia Indemnity Insurance Company	108252 Berkeley Insurance & Financial Servic 555 Pierce St, # 2 Albany, CA 94706 (510)984-0160
NAMED INSURED: Ascend Rehab Services, Inc.	
MAILING ADDRESS: 29516 Kohoutek Way Union City, CA 94587-1221	
POLICY PERIOD: FROM 03/04/2021 TO 03/04/2022 AT 12:01 A.M. STANDARD TIME AT YOUR MAILING ADDRESS SHOWN ABOVE	

IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL THE TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS POLICY.

LIMITS OF INSURANCE	
EACH OCCURRENCE LIMIT (LIABILITY COVERAGE)	\$ 1,000,000
PERSONAL & ADVERTISING INJURY LIMIT	\$ 1,000,000 Any one person or organization
PRODUCTS COMPLETED OPERATIONS AGGREGATE LIMIT	\$ 1,000,000
GENERAL AGGREGATE LIMIT (LIABILITY COVERAGE) (except with respect to Auto Liability and Products Completed Operations)	\$ 1,000,000

RETAINED LIMIT	
RETAINED LIMIT:	\$ 10,000

POLICY NUMBER: PHUB756257

PREMIUM	
PREMIUM SUBTOTAL	\$ 1,795.00
STATE TAXES, FEES, SURCHARGES (if applicable)	\$ <u>Not Applicable</u>
PREMIUM TOTAL (including Taxes, Fees, Surcharges)	\$ 1,795.00
AUDIT PERIOD: <input checked="" type="checkbox"/> NOT APPLICABLE <input type="checkbox"/> ANNUALLY <input type="checkbox"/> SEMI-ANNUALLY <input type="checkbox"/> QUARTERLY <input type="checkbox"/> MONTHLY	

DESCRIPTION OF BUSINESS	
FORM OF BUSINESS:	<u>CORPORATION</u>
BUSINESS DESCRIPTION:	<u>For Profit SS Umbrella</u>

ENDORSEMENTS ATTACHED TO THIS POLICY	
SEE ATTACHED SCHEDULE	

POLICY NUMBER: PHUB756257

SCHEDULE OF UNDERLYING INSURANCE		
Employers' Liability		
Company:		
Policy Number:		
Policy Period:		
Minimum Applicable Limits		
Bodily injury by accident	\$	Each Accident
Bodily injury by disease	\$	Each Employee
Bodily injury by disease	\$	Policy Limit
Commercial General Liability		
	<input checked="" type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company:	<u>Philadelphia Indemnity Insurance Company</u>	
Policy Number:	<u>PHPK2237024</u>	
Policy Period:	<u>03/04/2021</u> <u>03/04/2022</u>	
Retroactive Date:	<u>Not Applicable</u>	
Minimum Applicable Limits:		
General Aggregate	\$	3,000,000
Products-Completed Operations Aggregate	\$	3,000,000
Personal And Advertising Injury	\$	1,000,000
Each Occurrence	\$	1,000,000
Commercial Auto Liability		
Company:	<u>Philadelphia Indemnity Insurance Company</u>	
Policy Number:	<u>PHPK2237024</u>	
Policy Period:	<u>03/04/2021</u> <u>03/04/2022</u>	
Minimum Applicable Limits		
Garage Aggregate Limit For Other Than Autos (if applicable)	\$	Not Applicable
Each Accident	\$	1,000,000
Professional Liability		
	<input checked="" type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company:	<u>Philadelphia Indemnity Insurance Company</u>	
Policy Number:	<u>PHPK2237024</u>	
Policy Period:	<u>03/04/2021</u> <u>03/04/2022</u>	
Retroactive Date:	<u>Not Applicable</u>	
Minimum Applicable Limits		
<u>Each Professional Incident</u>	\$	1,000,000
<u>Aggregate</u>	\$	3,000,000

POLICY NUMBER: PHUB756257

Employee Benefits Liability	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____
Abusive Conduct Liability	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____
Directors & Officers Liability	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____
Liquor Liability	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____

POLICY NUMBER: PHUB756257

Watercraft Liability	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____
Other Coverages Not Included in Above	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made

Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____

THESE DECLARATIONS, TOGETHER WITH THE COMMON POLICY CONDITIONS AND COVERAGE FORM(S) AND ANY ENDORSEMENT(S), COMPLETE THE ABOVE NUMBERED POLICY.

Countersigned:	By:
(Date)	(Authorized Representative)

IN WITNESS WHEREOF, we have caused this policy to be executed and attested, and, if required by state law, this policy shall not be valid unless countersigned by our authorized representative.



John W. Glomb, Jr.
President & Chief Underwriting Officer



Secretary

Technology Insurance Company, Inc.

A Stock Insurance Company

WORKERS COMPENSATION
AND EMPLOYERS LIABILITY
INSURANCE POLICY

WC 99 00 01 E
1 of 5
INFORMATION PAGE

Ncci Code: 39071

1. Insured:

Ascend Rehab Services, Inc.
29516 Kohoutek Way
Union City, CA 94587

Other workplaces not shown above:

See Extension of Information Page

Producer:

AmTrust North America, Inc.
c/o ADP Insurance Services (NJ)
1 ADP Blvd., M/S 625
Roseland, NJ 07068

Policy Number: TWC3991773

Individual Partnership

Corporation or _____

Federal Tax ID: 200927823

Risk Id:

Renewal of: New

2. The policy period is from 6/1/2021 to 6/1/2022 12:01 a.m. at the insured's mailing address.

3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here: California

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in item 3.A. The limits of our liability under Part Two are:

<u>State</u>	<u>Bodily Injury by Accident</u>	<u>Bodily Injury by Disease</u>	<u>Bodily Injury by Disease</u>
	\$1,000,000 each accident	\$1,000,000 policy limit	\$1,000,000 each employee

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:

All states except ND, OH, WA, WY and State(s) Designated in Item 3A.

D. This policy includes these endorsements and schedules: See Extension of Information Page

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

See Extension of Information Page

TOTAL ESTIMATED ANNUAL PREMIUM

39,328

STATE ASSESSMENT

1,557

TOTAL ESTIMATED COST

40,885

Minimum Premium

500

Issue Date: 5/28/2021

Countersigned by: _____

Authorized Representative