

**CITY OF SAN ANTONIO**  
**SAN ANTONIO FIRE DEPARTMENT**



**REQUEST FOR PROPOSALS**  
**("RFP")**

for

**RADIOLOGY FOR SAN ANTONIO FIRE DEPARTMENT**  
**WELLNESS CENTER**

**(RFP 23-056; RFx 6100016942)**

**Release Date: June 29, 2023**  
**Proposals Due: August 1, 2023; 11:00 AM Central Time**

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**RESTRICTIONS ON COMMUNICATIONS**

In accordance with and as authorized by Section 2-61 of the City Code, the following restrictions on communications apply to this solicitation: Respondents are prohibited from contacting 1) City officials, as defined by §2-62 of the City Code of the City of San Antonio, regarding the RFP or proposal from the time the RFP has been released until the contract is posted for consideration as an agenda item during a meeting designated as an A session; and 2) City employees from the time the RFP has been released until the contract is approved at a City Council "A" session.

Restrictions extend to "thank you" letters, phone calls, emails and any contact that results in the direct or indirect discussion of the RFP and/or proposal submitted by Respondent.

Violation of this provision by Respondent and/or its agent may lead to disqualification of Respondent's proposal from consideration.

For additional information, see the section of this RFP entitled "Restrictions on Communication".

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**016 - RFP ATTACHMENTS**  
**RFP ATTACHMENT A, PART ONE**

**GENERAL INFORMATION**

1. **Respondent Information:** Provide the following information regarding the Respondent.  
(NOTE: Co-Respondents are two or more entities proposing as a team or joint venture with each signing the contract, if awarded. Sub-contractors are not Co-Respondents and should not be identified here. If this proposal includes Co-Respondents, provide the required information in this Item #1 for each Co-Respondent by copying and inserting an additional block(s) before Item #2.)

Respondent Name: VHS San Antonio Imaging Partners L.P.  
(NOTE: Give exact legal name as it will appear on the contract, if awarded.)

Principal Address: 4440 S. Piedras Dr., Suite 100

City: San Antonio State: Texas Zip Code: 78228

Telephone No. (210)785-2500 Fax No: (210)785-2572

Website address: www.baptistmsimaging.com

Year established: 2004

Provide the number of years in business under present name: 15 years

Social Security Number or Federal Employer Identification Number: 33-1082073

Texas Comptroller's Taxpayer Number, if applicable: N/A

(NOTE: This 11-digit number is sometimes referred to as the Comptroller's TIN or TID.)

DUNS NUMBER: N/A

Unique Entity ID (generated by SAM.gov): \_\_\_\_\_

Business Structure: Check the box that indicates the business structure of the Respondent.

☐ Individual or Sole Proprietorship. If checked, list Assumed Name, if any: \_\_\_\_\_  
☒ Partnership  
☐ Corporation If checked, check one: ☐ For-Profit ☐ Nonprofit  
Also, check one: ☐ Domestic ☐ Foreign  
☐ Other If checked, list business structure: \_\_\_\_\_

Printed Name of Contract Signatory: Vicki Dear

Job Title: Regional Vice President

Provide any other names under which Respondent has operated within the last 10 years and length of time under for each: N/A

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provide address of office from which this project would be managed:  
City: San Antonio State: Texas Zip Code: 78228

Telephone No. (210) 785-2500 Fax No: (210) 785-2572

Annual Revenue: \$ \_\_\_\_\_

Total Number of Employees: \_\_\_\_\_

Total Number of Current Clients/Customers: \_\_\_\_\_

Briefly describe other lines of business that the company is directly or indirectly affiliated with:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Related Companies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. **Contact Information:** List the one person who the City may contact concerning your proposal or setting dates for meetings.

Name: VENKATESH SARANRAJ Title: DIRECTOR OF REVENUE CYCLE

Address: 4440 PIEDRAS DR SOUTH #100

City: SAN ANTONIO State: TEXAS Zip Code: 78228

Telephone No. 830-745-1056 Fax No: 210-785-2539

Email: sxvenka1@BaptistHealthSystem.com

3. Does Respondent anticipate any mergers, transfer of organization ownership, management reorganization, or departure of key personnel within the next twelve (12) months?

Yes ☐ No ☒

4. Is Respondent authorized to do business with the State of Texas Secretary of State?

Yes ☒ No ☐ If "Yes", provide registration number.

\_\_\_\_\_  
\_\_\_\_\_

5. Where is the Respondent's corporate headquarters located? SAN ANTONIO

6. **Local/County Operation:** Does the Respondent have an office located in San Antonio, Texas?

Yes ☒ No ☐ If "Yes", respond to a and b below:

- a. How long has the Respondent conducted business from its San Antonio office?

Years 15 Months \_\_\_\_\_

- b. State the number of full-time employees at the San Antonio office.

If "No", indicate if Respondent has an office located within Bexar County, Texas:

Yes ☐ No ☐ If "Yes", respond to c and d below:

- c. How long has the Respondent conducted business from its Bexar County office?

Years \_\_\_\_\_ Months \_\_\_\_\_

- d. State the number of full-time employees at the Bexar County office. \_\_\_\_\_



7. **Debarment/Suspension Information:** Has the Respondent or any of its principals been debarred or suspended from contracting with any public entity?

Yes \_\_\_\_ No X If "Yes", identify the public entity and the name and current phone number of a representative of the public entity familiar with the debarment or suspension, and state the reason for or circumstances surrounding the debarment or suspension, including but not limited to the period of time for such debarment or suspension.

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8. **Surety Information:** Has the Respondent ever had a bond or surety canceled or forfeited?

Yes \_\_\_\_ No X If "Yes", state the name of the bonding company, date, amount of bond and reason for such cancellation or forfeiture.

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9. **Bankruptcy Information:** Has the Respondent ever been declared bankrupt or filed for protection from creditors under state or federal proceedings?

Yes \_\_\_\_ No X If "Yes", state the date, court, jurisdiction, cause number, amount of liabilities and amount of assets.

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10. **Disciplinary Action:** Has the Respondent ever received any disciplinary action, or any pending disciplinary action, from any regulatory bodies or professional organizations? Yes \_\_\_\_ No X If "Yes", state the name of the regulatory body or professional organization, date and reason for disciplinary or impending disciplinary action.

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11. **Previous Contracts:**

- a. Has the Respondent ever failed to complete any contract awarded?

Yes \_\_\_\_ No X If "Yes", state the name of the organization contracted with, services contracted, date, contract amount and reason for failing to complete the contract.

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- b. Has any officer or partner proposed for this assignment ever been an officer or partner of some other organization that failed to complete a contract?

Yes \_\_\_\_ No X If "Yes", state the name of the individual, organization contracted with, services contracted, date, contract amount and reason for failing to complete the contract.

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- c. Has any officer or partner proposed for this assignment ever failed to complete a contract handled in his or her own name?

Yes \_\_\_\_ No X If "Yes", state the name of the individual, organization contracted with, services contracted, date, contract amount and reason for failing to complete the contract.

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12. **Financial Review:** Is your firm publicly traded? Yes X No \_\_\_\_ If "Yes", provide your firm's SEC filing number.

NO SEC FILING NUMBER [WE ARE A PARTNERSHIP] [NO CORPORATION]

## REFERENCES

Provide three (3) reference letters from three (3) separate organizations/companies/firms, that the Respondent has provided services to within the past three (3) years. The contact person named on the reference letter should be familiar with the day-to-day management of the contract and would be able to provide type, level, and quality of services performed. In addition, please provide the contact information below of the references you have submitted.

### Reference No. 1:

Firm/Company Name Methodist Healthcare Ministries  
Contact Name: Oluyinka Sokunbi Title: Clinic Administrator  
Address: \_\_\_\_\_  
City: San Antonio State: Texas Zip Code: 78211  
Email: osokunbi@mhm.org  
Telephone No. (210)922-6922 Fax No: \_\_\_\_\_  
Date and Type of Service(s) Provided: Diagnostic Radiology and Imaging Services

### Reference No. 2:

Firm/Company Name Communicare Health Centers  
Contact Name: Quiara Sherrard Title: Chief Revenue Officer  
Address: 3066 E Commerce St.  
City: San Antonio State: Texas Zip Code: 78220  
Email: \_\_\_\_\_  
Telephone No. (210) 233-7093 Fax No: (210)277-5199  
Date and Type of Service(s) Provided: Diagnostic Radiology and Imaging Services

### Reference No. 3:

Firm/Company Name CentroMed (Centro Del Barrio)  
Contact Name: Margarita Seaman Title: Revenue Enhancement Officer  
Address: 3750 Commercial Ave.  
City: San Antonio State: Texas Zip Code: 78221  
Email: margarita.seaman@centromedsa.com  
Telephone No. (210)334-3717 Fax No: \_\_\_\_\_  
Date and Type of Service(s) Provided: Diagnostic Radiology and Imaging Services

RFP ATTACHMENT D

LITIGATION DISCLOSURE FORM

Respond to each of the questions below by checking the appropriate box. Failure to fully and truthfully disclose the information required by this Litigation Disclosure form may result in the disqualification of your proposal from consideration or termination of the contract, once awarded.

Have you or any member of your Firm or Team to be assigned to this engagement ever been indicted or convicted of a felony or misdemeanor greater than a Class C in the last five (5) years?

Yes ☐ No ☒

Have you or any member of your Firm or Team to be assigned to this engagement been terminated (for cause or otherwise) from any work being performed for the City of San Antonio or any other Federal, State or Local Government, or Private Entity?

Yes ☐ No ☒

Have you or any member of your Firm or Team to be assigned to this engagement been involved in any claim or litigation with the City of San Antonio or any other Federal, State or Local Government, or Private Entity during the last ten (10) years?

Yes ☐ No ☒

If you have answered "Yes" to any of the above questions, please indicate the name(s) of the person(s), the nature, and the status and/or outcome of the information, indictment, conviction, termination, claim, or litigation, as applicable. Any such information should be provided on a separate page, attached to this form, and submitted with your proposal.

## RFP ATTACHMENT G

### CERTIFICATE OF INTERESTED PARTIES (Form 1295)

Texas Government Code §2252.908, and the rules issued by the Texas Ethics Commission found in Title 1, Sections 46.1, 46.3 and 46.5 of the Texas Administrative Code, require a business entity to submit a completed Form 1295 to the City before the City may enter into a contract with that business entity.

Form 1295 must be completed online. It is available from the Texas Ethics Commission by accessing the following web address: <https://www.ethics.state.tx.us/filinginfo/1295>

Print and sign your completed Form 1295. Submit your signed Form 1295 with your response to this solicitation. Where requested to provide the name of the public entity with whom you are contracting, insert "City of San Antonio". Where requested to provide the contract number, provide the RFP number shown on the cover page of this solicitation (e.g. IFB 6100001234, RFO 6100001234, or RFCSP 6100001234).

The following definitions found in the statute and Texas Ethics Commission rules may be helpful in completing Form 1295.

"Business entity" includes an entity through which business is conducted with a governmental entity or state agency, regardless of whether the entity is a for-profit or nonprofit entity. The term does not include a governmental entity or state agency. (NOTE: The City of San Antonio should never be listed as the "Business entity".)

"Controlling interest" means: (1) an ownership interest or participating interest in a business entity by virtue of units, percentage, shares, stock, or otherwise that exceeds 10 percent; (2) membership on the board of directors or other governing body of a business entity of which the board or other governing body is composed of not more than 10 members; or (3) service as an officer of a business entity that has four or fewer officers, or service as one of the four officers most highly compensated by a business entity that has more than four officers. Subsection (3) of this section does not apply to an officer of a publicly held business entity or its wholly owned subsidiaries.

"Interested party" means: (1) a person who has a controlling interest in a business entity with whom a governmental entity or state agency contracts; or (2) an intermediary.

"Intermediary," for purposes of this rule, means, a person who actively participates in the facilitation of the contract or negotiating the contract, including a broker, adviser, attorney, or representative of or agent for the business entity who:

(1) receives compensation from the business entity for the person's participation;

(2) communicates directly with the governmental entity or state agency on behalf of the business entity regarding the contract; and

(3) is not an employee of the business entity or of an entity with a controlling interest in the business entity.

Publicly traded business entities, including their wholly owned subsidiaries, are exempt from this requirement and are not required to submit Form 1295.



1 of 1

Date Acknowledged:

- Version V1.0.6711

## RFP ATTACHMENT H

### SIGNATURE PAGE

Respondent, and co-respondent, if any, must complete City's Certified Vendor Registration (CVR) Form prior to the due date for submission of proposals. The CVR Form may be accessed at:  
<https://www.sa.gov/Directory/Departments/Finance/About/Divisions/Procurement>.

By submitting a proposal, electronically, Respondent represents that:

If awarded a contract in response to this RFP, Respondent will be able and willing to execute a contract with the understanding that the scope and compensation provisions will be negotiated and included in the final document.

If Respondent is a corporation, Respondent will be required to provide a certified copy of the resolution evidencing authority to enter into the contract, if other than an officer will be signing the contract.

If awarded a contract in response to this RFP, Respondent will be able and willing to comply with the insurance and indemnification requirements set out in RFP Exhibits 1 & 2.

If awarded a contract in response to this RFP, Respondent will be able and willing to comply with all representations made by Respondent in Respondent's proposal and during Proposal process.

Respondent has fully and truthfully submitted a Litigation Disclosure form with the understanding that failure to disclose the required information may result in disqualification of proposal from consideration.

Respondent agrees to fully and truthfully submit the Respondent General Information form and understands that failure to fully disclose requested information may result in disqualification of proposal from consideration or termination of contract, once awarded.

To comply with the City's Ethics Code, particularly Section 2-61 that prohibits a person or entity seeking a City contract - or any other person acting on behalf of such a person or entity - from contacting City officials or their staff prior to the time such contract is posted as a City Council agenda item.

(S) he is authorized to submit this proposal on behalf of the entity.

Complete the following and sign on the signature line below. Failure to sign and submit this Signature Page will result in rejection of your proposal.

VHS SAN ANTONIO IMAGING PARTNERS LP  
Respondent Entity Name

Signature: Vicki Dean

Printed Name: VICKI DEAN

Title: REGIONAL VICE PRESIDENTS

(NOTE: If proposal is submitted by Co-Respondents, an authorized signature from a representative of each Co-Respondent is required. Add additional signature blocks as required.)

When submitting your proposal electronically, through City's portal, Co-Respondent must also log in using Co-Respondent's log-on ID and password, and submit a letter indicating that Co-Respondent is a party to Respondent's proposal and agrees to these representations and those made in Respondent's proposal. While Co-Respondent does not have to submit a copy of Respondent's proposal, Co-Respondent should answer any questions or provide any information directed specifically to Co-Respondent.

## RFP ATTACHMENT I

### PROPOSAL CHECKLIST

Use this checklist to ensure that all required documents have been included in the proposal and appear in the correct order. Respondent shall limit information regarding the the Local Preference Program, the Veteran-Owned Small Business Preference Program participation and any reference to the Respondent's proposed price or revenue to the respective section designated for this information. **PLACING PROGRAM PARTICIPATION OR PRICE/REVENUE INFORMATION IN OTHER SECTIONS OF A RESPONSE TO THIS RFP MAY RESULT IN THE RESPONDENT'S PROPOSAL BEING DEEMED NON-RESPONSIVE AND THEREFORE DISQUALIFIED FROM CONSIDERATION.**

Document	Initial to Indicate Document is attached to Proposal
Table of Contents	GP
Executive Summary	GP
General Information Form and Three (3) Reference Letters RFP Attachment A, Part One	GP
Experience, Background and Qualifications RFP Attachment A, Part Two	GP
Proposed Plan RFP Attachment A, Part Three	GP
Price Schedule RFP Attachment B	GP
+Contracts Disclosure Form RFP Attachment C	GP
Litigation Disclosure Form RFP Attachment D	GP
+Local Preference Program Identification Form RFP Attachment E	GP
+Veteran-Owned Small Business Preference Program Identification Form RFP Attachment F	GP
Proof of Insurability (See RFP Exhibit 1) Insurance Provider's Letter and Copy of Current Certificate of Insurance	GP
Financial Information	GP
+Certificate of Interested Parties (Form 1295) RFP Attachment G	GP
+Signature Page RFP Attachment H	GP
Proposal Checklist RFP Attachment I	GP.
+Signed Addenda, if applicable.	
One <b>COMPLETE</b> (1) electronic submission through SAePS.	

+Documents marked with a (+) on this checklist require a signature.

**Be sure all forms that require a signature are done so prior to submittal of the proposal.**





# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

5/31/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an **ADDITIONAL INSURED**, the policy(ies) must have **ADDITIONAL INSURED** provisions or be endorsed. If **SUBROGATION** IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> Arthur J. Gallagher Risk Management Services, LLC 500 N. Brand Boulevard Suite 100 Glendale CA 91203	<b>CONTACT</b> NAME: Global Risk Management PHONE (A/C, No, Ext): 818-539-2300 E-MAIL ADDRESS: grm_certificates@ajg.com	<b>FAX</b> (A/C, No): 818-539-1801
<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
INSURER A: Various		
INSURER B: National Union Fire Insurance Company of Pittsburg		19445
INSURER C:		
INSURER D:		
INSURER E:		
INSURER F:		

**COVERAGES**

CERTIFICATE NUMBER: 57242211

REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
B	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	Y		1728920	6/1/2023	6/1/2024	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 1,000,000 MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000 \$
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
A	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N <input checked="" type="checkbox"/> N	N/A	See Attached	6/1/2023	6/1/2024	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 2,000,000 E.L. DISEASE - EA EMPLOYEE \$ 2,000,000 E.L. DISEASE - POLICY LIMIT \$ 2,000,000

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**

Insured/Facility: VHS San Antonio Imaging Partners LP dba Baptist M&S Imaging Breast Center Re: Leased Premises at 540 Madison Oak Drive, San Antonio, TX, Suite 160 (Breast Center). Other suites covered by this policy: 110, 200, 360, 570, 615 & 620 HCP Stone Oak MOB LP and Lincoln Harris CSG are included as Additional Insured with respect to Liability but solely as respects to Liability Arising out of the Named Insured's Operations or Premises Owned by or rented by the Named Insured, excluding Contract or Agreements for Professional Services, and Subject to the Terms and Conditions of the referenced policy as required by written contract. Waiver of Subrogation is afforded to same.

**CERTIFICATE HOLDER****CANCELLATION**

HCP Stone Oak MOB, LP c/o Lincoln Harris CSG  
525 Oak Centre Drive, Ste 240  
San Antonio TX 78258

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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**Tenet Healthcare Corporation****Workers' Compensation Program**

Layer	Insurance Company	Policy Number	Policy Term	NAIC No.
Work Comp - AOS (AK AR AZ CO CT DE FL GA HI IA ID IL IN KS KY MA MD ME MI MN MO MS MT NC NE NH NJ NM NV NY OK OR PA RI SC SD TN TX UT VA VT WV)	AIU Insurance Company	15824993	06/01/23- 06/01/24	23841
Work Comp - WI	AIU Insurance Company	15824994	06/01/23- 06/01/24	23841
Work Comp - CA	AIU Insurance Company	15824995	06/01/23- 06/01/24	23841
Excess Work Comp-AL, CA, LA	National Union Fire Insurance Company of Pittsburgh, Pa.	1647412	06/01/23- 06/01/24	19445
Excess Work Comp - MI (VHS of Michigan, Inc.)	Safety National Casualty Corporation	SP 4066571	06/01/23- 06/01/24	15105



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

5/31/2023

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**IMPORTANT:** If the certificate holder is an **ADDITIONAL INSURED**, the policy(ies) must have **ADDITIONAL INSURED** provisions or be endorsed. If **SUBROGATION** IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> Arthur J. Gallagher Risk Management Services, LLC 500 N. Brand Boulevard Suite 100 Glendale CA 91203	<b>CONTACT</b> NAME: Global Risk Management PHONE (A/C, No, Ext): 818-539-2300 E-MAIL ADDRESS: grm_certificates@ajg.com	<b>FAX</b> (A/C, No): 818-539-1801
<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
INSURER A: National Union Fire Insurance Company of Pittsburg		19445
INSURER B: Various		
INSURER C: AIU Insurance Company		19399
INSURER D:		
INSURER E:		
INSURER F:		

**COVERAGES**

CERTIFICATE NUMBER: 1030553213

REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	Y	Y	1728920	6/1/2023	6/1/2024	EACH OCCURRENCE \$ 5,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 1,000,000 MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ 2,000,000 GENERAL AGGREGATE \$ 5,000,000 PRODUCTS - COMP/OP AGG \$ 5,000,000 \$
A C	<input checked="" type="checkbox"/> <b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY	Y	Y	4594321 4594322	6/1/2023 6/1/2023	6/1/2024 6/1/2024	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ Phys Damage/Ded \$ 250,000
	<input type="checkbox"/> <b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR <input type="checkbox"/> <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
B	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N <input checked="" type="checkbox"/> N	Y	See Attached	6/1/2023	6/1/2024	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 2,000,000 E.L. DISEASE - EA EMPLOYEE \$ 2,000,000 E.L. DISEASE - POLICY LIMIT \$ 2,000,000

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**

Insured/Facility: BHS Physicians Network, Inc. Re: leased premises at 4103 North Loop 1604, Ste 212, San Antonio, TX 78257 (MedFirst) 318 NW San Antonio Venture LLC, Emerus BHS / SA NW Military LLC & Transwestern Commercial Services LLC are included as Additional Insureds by written contract, agreement or permit. A waiver of Subrogation applies to all policies referenced herein. is included as Additional Insured with respect to General Liability but solely as respects to Liability Arising out of the Named Insured's Operations or Premises Owned by or rented by the Named Insured, excluding Contract or Agreements for Professional Services, and Subject to the Terms and Conditions of the referenced policy as required by written contract.

**CERTIFICATE HOLDER****CANCELLATION**

Emerus BHS / SA NW Military, LLC  
8686 New Trails Drive, Suite 100  
The Woodlands TX 77381

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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**Tenet Healthcare Corporation****Workers' Compensation Program**

Layer	Insurance Company	Policy Number	Policy Term	NAIC No.
Work Comp - AOS (AK AR AZ CO CT DE FL GA HI IA ID IL IN KS KY MA MD ME MI MN MO MS MT NC NE NH NJ NM NV NY OK OR PA RI SC SD TN TX UT VA VT WV)	AIU Insurance Company	15824993	06/01/23- 06/01/24	23841
Work Comp - WI	AIU Insurance Company	15824994	06/01/23- 06/01/24	23841
Work Comp - CA	AIU Insurance Company	15824995	06/01/23- 06/01/24	23841
Excess Work Comp-AL, CA, LA	National Union Fire Insurance Company of Pittsburgh, Pa.	1647412	06/01/23- 06/01/24	19445
Excess Work Comp - MI (VHS of Michigan, Inc.)	Safety National Casualty Corporation	SP 4066571	06/01/23- 06/01/24	15105



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

5/31/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an **ADDITIONAL INSURED**, the policy(ies) must have **ADDITIONAL INSURED** provisions or be endorsed. If **SUBROGATION** IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> Arthur J. Gallagher Risk Management Services, LLC 500 N. Brand Boulevard Suite 100 Glendale CA 91203	<b>CONTACT</b> NAME: Global Risk Management PHONE (A/C, No, Ext): 818-539-2300 E-MAIL ADDRESS: grm_certificates@ajg.com	<b>FAX</b> (A/C, No): 818-539-1801
<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
INSURER A : National Union Fire Insurance Company of Pittsburg		19445
INSURER B : Various		
INSURER C : AIU Insurance Company		19399
INSURER D :		
INSURER E :		
INSURER F :		

**COVERAGES****CERTIFICATE NUMBER:** 1149011314**REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	Y	Y	1728920	6/1/2023	6/1/2024	EACH OCCURRENCE \$ 5,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 1,000,000 MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ 2,000,000 GENERAL AGGREGATE \$ 5,000,000 PRODUCTS - COMP/OP AGG \$ 5,000,000 \$
A C	<input checked="" type="checkbox"/> <b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY	Y	Y	4594321 4594322	6/1/2023 6/1/2023	6/1/2024 6/1/2024	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ Phys Damage/Ded \$ 250,000
	<input type="checkbox"/> <b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR <input type="checkbox"/> <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
B	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y / N N	Y	See Attached	6/1/2023	6/1/2024	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 2,000,000 E.L. DISEASE - EA EMPLOYEE \$ 2,000,000 E.L. DISEASE - POLICY LIMIT \$ 2,000,000

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**

Insured Facility: VHS San Antonio Partners LLC dba Medfirst, M&S Imaging and Timeshare Re: Leased premises at 16977 I-35 North, Schertz, TX 78154 - suites 210 (Medfirst), 220 (M&S Imaging), 212 & 280 (Timeshare), 200 & 260. Certificate Holder and Jones Lang La Salle Americas Inc are included as Additional Insured with respect to General Liability but solely as respects to liability arising out of the Named Insured's operations or premises owned by or rented by the Named Insured, excluding contract or agreements for Professional Services, and subject to the terms and conditions of the referenced policy as required by written contract per the attached policy form.

**CERTIFICATE HOLDER****CANCELLATION**

EMERUS / BHS SA SCHERTZ, LLC  
Emerus Hospital Partners, Inc  
8686 New Trails Drive  
The Woodlands TX 77381  
USA

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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**Tenet Healthcare Corporation****Workers' Compensation Program**

Layer	Insurance Company	Policy Number	Policy Term	NAIC No.
Work Comp - AOS (AK AR AZ CO CT DE FL GA HI IA ID IL IN KS KY MA MD ME MI MN MO MS MT NC NE NH NJ NM NV NY OK OR PA RI SC SD TN TX UT VA VT WV)	AIU Insurance Company	15824993	06/01/23- 06/01/24	23841
Work Comp - WI	AIU Insurance Company	15824994	06/01/23- 06/01/24	23841
Work Comp - CA	AIU Insurance Company	15824995	06/01/23- 06/01/24	23841
Excess Work Comp-AL, CA, LA	National Union Fire Insurance Company of Pittsburgh, Pa.	1647412	06/01/23- 06/01/24	19445
Excess Work Comp - MI (VHS of Michigan, Inc.)	Safety National Casualty Corporation	SP 4066571	06/01/23- 06/01/24	15105

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

## ADDITIONAL INSURED – MANAGERS OR LESSORS OF PREMISES

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

### SCHEDULE

<b>Designation Of Premises (Part Leased To You):</b> PER THE CONTRACT OR AGREEMENT
<b>Name Of Person(s) Or Organization(s) (Additional Insured):</b> ANY PERSON OR ORGANIZATION FROM WHOM YOU LEASE PREMISES OR WHO MANAGES PREMISES YOU OWN AND TO WHOM YOU BECOME OBLIGATED TO INCLUDE AS AN ADDITIONAL INSURED UNDER THIS POLICY AS A RESULT OF ANY LEASE OR MANAGEMENT AGREEMENT YOU ENTER INTO WITH SUCH PARTIES
<b>Additional Premium:</b> \$ INCLUDED
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

**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 arising out of the ownership, maintenance or use of that part of the premises leased to you and shown in the Schedule and subject to the following additional exclusions:

This insurance does not apply to:

1. Any "occurrence" which takes place after you cease to be a tenant in that premises.
2. Structural alterations, new construction or demolition operations performed by or on behalf of the person(s) or organization(s) shown in the Schedule.

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.



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No, E-MAIL ADDRESS:</b>		<b>FAX (A/C, No):</b>
	<b>INSURER(S) AFFORDING COVERAGE</b>		
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
	<b>INSURER B :</b>		
<b>INSURED</b>  Baptist Breast Center - Westover Hills 3903 Wiseman Blvd, Suite 321 San Antonio, TX 78251	<b>NAIC #</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	EACH OCCURRENCE	\$ 10,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
	<input checked="" type="checkbox"/> Medical Professional Liability						MED EXP (Any one person)	\$
							PERSONAL & ADV INJURY	\$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	\$ 10,000,000
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG	\$
	OTHER:						\$	
	<b>AUTOMOBILE LIABILITY</b>						COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person)	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						BODILY INJURY (Per accident)	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$
								\$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR						EACH OCCURRENCE	\$
	<b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE						AGGREGATE	\$
	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> N		N/A				E.L. EACH ACCIDENT	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	\$
								\$
							E.L. DISEASE - POLICY LIMIT	

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**

see below

All employees of Insured are provided coverage under this policy, including residents, interns, nurse practitioners, nurse midwives, athletic trainers, physician assistants, profusionists, therapists, social workers, CRNA's podiatrists, paramedics and employed physicians while acting within the scope of their duties as such. Also covered are authorized Volunteers and facility Medical Directors while acting within the scope of their duties as such.

**CERTIFICATE HOLDER****CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

**AUTHORIZED REPRESENTATIVE**

Marsh Management Services Cayman Ltd.

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No,):</b>	<b>FAX (A/C, No):</b>	
	<b>E-MAIL ADDRESS:</b>		
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
<b>INSURED</b>  Baptist M&S Imaging (Business Office) 4440 Piedras Drive South, Ste 100 San Antonio, TX 78228	<b>INSURER B :</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	EACH OCCURRENCE	\$ 10,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
	<input checked="" type="checkbox"/> Medical Professional Liability						MED EXP (Any one person)	\$
							PERSONAL & ADV INJURY	\$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	\$ 10,000,000
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG	\$
	OTHER:						\$	
	<b>AUTOMOBILE LIABILITY</b>						COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person)	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						BODILY INJURY (Per accident)	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$
								\$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR						EACH OCCURRENCE	\$
	<b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE						AGGREGATE	\$
	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> N						E.L. EACH ACCIDENT	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	\$
								\$
							E.L. DISEASE - POLICY LIMIT	

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**

Evidence of Coverage

All employees of Insured are provided coverage under this policy, including residents, interns, nurse practitioners, nurse midwives, athletic trainers, physician assistants, profusionists, therapists, social workers, CRNA's podiatrists, paramedics and employed physicians while acting within the scope of their duties as such. Also covered are authorized Volunteers and facility Medical Directors while acting within the scope of their duties as such.

**CERTIFICATE HOLDER****CANCELLATION**

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**AUTHORIZED REPRESENTATIVE**

Marsh Management Services Cayman Ltd.

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

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<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No,):</b>		<b>FAX (A/C, No):</b>
	<b>E-MAIL ADDRESS:</b>		
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
<b>INSURED</b>  Baptist M&S Imaging - Legacy Oaks 5368 Fredericksburg Rd, Suite 305 San Antonio, TX 78229	<b>INSURER B :</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	<b>EACH OCCURRENCE</b>	\$ 10,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.		<b>DAMAGE TO RENTED PREMISES (Ea occurrence)</b>				\$	
	<input checked="" type="checkbox"/> Medical Professional Liability		<b>MED EXP (Any one person)</b>				\$	
			<b>PERSONAL &amp; ADV INJURY</b>				\$	
	GEN'L AGGREGATE LIMIT APPLIES PER:		<b>GENERAL AGGREGATE</b>				\$ 10,000,000	
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC		<b>PRODUCTS - COMP/OP AGG</b>				\$	
	OTHER:						\$	
	<b>AUTOMOBILE LIABILITY</b>						<b>COMBINED SINGLE LIMIT (Ea accident)</b>	\$
	<input type="checkbox"/> ANY AUTO						<b>BODILY INJURY (Per person)</b>	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						<b>BODILY INJURY (Per accident)</b>	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						<b>PROPERTY DAMAGE (Per accident)</b>	\$
								\$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR						<b>EACH OCCURRENCE</b>	\$
	<b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE						<b>AGGREGATE</b>	\$
	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> N		N/A				<b>E.L. EACH ACCIDENT</b>	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						<b>E.L. DISEASE - EA EMPLOYEE</b>	\$
								\$
							<b>E.L. DISEASE - POLICY LIMIT</b>	

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**

see below

All employees of Insured are provided coverage under this policy, including residents, interns, nurse practitioners, nurse midwives, athletic trainers, physician assistants, profusionists, therapists, social workers, CRNA's podiatrists, paramedics and employed physicians while acting within the scope of their duties as such. Also covered are authorized Volunteers and facility Medical Directors while acting within the scope of their duties as such.

**CERTIFICATE HOLDER****CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Marsh Management Services Cayman Ltd.

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

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**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No, E-MAIL ADDRESS:</b>		<b>FAX (A/C, No):</b>
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
	<b>INSURER B :</b>		
<b>INSURED</b>  Baptist M & S Imaging Partners 215 E. Quincy, Suite 100 San Antonio, TX 78215	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.	EACH OCCURRENCE	\$ 10,000,000
	<input checked="" type="checkbox"/> Medical Professional Liability						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$	
							MED EXP (Any one person)	\$	
							PERSONAL & ADV INJURY	\$	
							GENERAL AGGREGATE	\$ 10,000,000	
	GEN'L AGGREGATE LIMIT APPLIES PER:								
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC								
	OTHER:								
	<b>AUTOMOBILE LIABILITY</b>								
	<input type="checkbox"/> ANY AUTO							COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS							BODILY INJURY (Per person)	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY							BODILY INJURY (Per accident)	\$
								PROPERTY DAMAGE (Per accident)	\$
									\$
	<b>UMBRELLA LIAB</b>							EACH OCCURRENCE	\$
	<b>EXCESS LIAB</b>							AGGREGATE	\$
	DED <input type="checkbox"/> RETENTION \$								\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>								
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)							PER STATUTE	
	If yes, describe under DESCRIPTION OF OPERATIONS below							OTH-ER	
								E.L. EACH ACCIDENT	\$
								E.L. DISEASE - EA EMPLOYEE	\$
									\$
								E.L. DISEASE - POLICY LIMIT	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

see below

**For Insurance Verification Purposes**

All employees of Insured are provided coverage under this policy, including residents, interns, nurse practitioners, nurse midwives, athletic trainers, physician assistants, profusionists, therapists, social workers, CRNA's podiatrists, paramedics and employed physicians while acting within the scope of their duties as such. Also covered are authorized Volunteers and facility Medical Directors while acting within the scope of their duties as such.

**CERTIFICATE HOLDER****CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

**AUTHORIZED REPRESENTATIVE**

Marsh Management Services Cayman Ltd.

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

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<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No,):</b>		<b>FAX (A/C, No):</b>
	<b>E-MAIL ADDRESS:</b>		
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
<b>INSURED</b>  Baptist M&S Imaging Downtown 215 E. Quincy, Suite 100 San Antonio, TX 78215	<b>INSURER B :</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		


**COVERAGES**                      **CERTIFICATE NUMBER:**                      **REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	EACH OCCURRENCE	\$ 10,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
	<input checked="" type="checkbox"/> Medical Professional Liability						MED EXP (Any one person)	\$
							PERSONAL & ADV INJURY	\$
							GENERAL AGGREGATE	\$ 10,000,000
							PRODUCTS - COMP/OP AGG	\$
GEN'L AGGREGATE LIMIT APPLIES PER:								
	POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC							
	OTHER:							
	<b>AUTOMOBILE LIABILITY</b>						COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person)	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						BODILY INJURY (Per accident)	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$
								\$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR						EACH OCCURRENCE	\$
	<b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE						AGGREGATE	\$
	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						PER STATUTE	OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> N						E.L. EACH ACCIDENT	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	\$
								\$
							E.L. DISEASE - POLICY LIMIT	

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**  
Evidence of Coverage

All employees of Insured are provided coverage under this policy, including residents, interns, nurse practitioners, nurse midwives, athletic trainers, physician assistants, profusionists, therapists, social workers, CRNA's podiatrists, paramedics and employed physicians while acting within the scope of their duties as such. Also covered are authorized Volunteers and facility Medical Directors while acting within the scope of their duties as such.

<b>CERTIFICATE HOLDER</b>  Baptist M&S Imaging Downtown 215 E. Quincy, Suite 100 San Antonio, TX 78215	<b>CANCELLATION</b> SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.  <b>AUTHORIZED REPRESENTATIVE</b>   Marsh Management Services Cayman Ltd.
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

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<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No,):</b>		<b>FAX (A/C, No):</b>
	<b>E-MAIL ADDRESS:</b>		
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
<b>INSURED</b>  Baptist M&S Imaging - Mission Trail 3327 Research Plaza, Suite 108 San Antonio, TX 78235	<b>INSURER B :</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		

**COVERAGES**                      **CERTIFICATE NUMBER:**                      **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	EACH OCCURRENCE	\$ 10,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
	<input checked="" type="checkbox"/> Medical Professional Liability						MED EXP (Any one person)	\$
							PERSONAL & ADV INJURY	\$
							GENERAL AGGREGATE	\$ 10,000,000
							PRODUCTS - COMP/OP AGG	\$
	GEN'L AGGREGATE LIMIT APPLIES PER:							
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC							
	OTHER:							
	<b>AUTOMOBILE LIABILITY</b>						COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person)	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						BODILY INJURY (Per accident)	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$
								\$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR						EACH OCCURRENCE	\$
	<b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE						AGGREGATE	\$
	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> N						E.L. EACH ACCIDENT	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	\$
								\$
							E.L. DISEASE - POLICY LIMIT	

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**  
see below

Re: Evidence of Insurance  
All employees of Insured are provided coverage under this policy, including residents, interns, nurse practitioners, nurse midwives, athletic trainers, physician assistants, profusionists, therapists, social workers, CRNA's podiatrists, paramedics and employed physicians while acting within the scope of their duties as such. Also covered are authorized Volunteers and facility Medical Directors while acting within the scope of their duties as such.

<b>CERTIFICATE HOLDER</b>  Baptist M&S Imaging - Mission Trail 3327 Research Plaza, Suite 108 San Antonio, TX 78235	<b>CANCELLATION</b> SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	<b>AUTHORIZED REPRESENTATIVE</b>   Marsh Management Services Cayman Ltd.

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# CERTIFICATE OF LIABILITY INSURANCE

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03/25/2023

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<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No, E-MAIL ADDRESS:</b>		<b>FAX (A/C, No):</b>
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
<b>INSURED</b>  VHS San Antonio Imaging Partners LP dba Baptist M&S Imaging - New Braunfels 1763 Medical Way New Braunfels, TX 78132	<b>INSURER B :</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	EACH OCCURRENCE	\$ 10,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.		DAMAGE TO RENTED PREMISES (Ea occurrence)				\$	
	<input checked="" type="checkbox"/> Medical Professional Liability		MED EXP (Any one person)				\$	
			PERSONAL & ADV INJURY				\$	
	GEN'L AGGREGATE LIMIT APPLIES PER:		GENERAL AGGREGATE				\$ 10,000,000	
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC		PRODUCTS - COMP/OP AGG				\$	
	OTHER:						\$	
	<b>AUTOMOBILE LIABILITY</b>						COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person)	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						BODILY INJURY (Per accident)	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$
								\$
	<b>UMBRELLA LIAB</b>						EACH OCCURRENCE	\$
	<b>EXCESS LIAB</b>						AGGREGATE	\$
	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						PER STATUTE	OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)						E.L. EACH ACCIDENT	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	\$
								\$
							E.L. DISEASE - POLICY LIMIT	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Evidence of Coverage

**CERTIFICATE HOLDER****CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Marsh Management Services Cayman Ltd.

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CERTIFICATE OF LIABILITY INSURANCE

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PRODUCER  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	CONTACT NAME:		
	PHONE (A/C, No,		FAX (A/C, No):
	E-MAIL ADDRESS:		
	INSURER(S) AFFORDING COVERAGE		NAIC #
	INSURER A : The Healthcare Insurance Corporation		
INSURED  Baptist M & S Imaging, North Central Breast Center 502 Madison Oak, Suite 450 San Antonio, TX 78258	INSURER B :		
	INSURER C :		
	INSURER D :		
	INSURER E :		
	INSURER F :		

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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INSR LTR	TYPE OF INSURANCE			ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS				
A	<input checked="" type="checkbox"/>	COMMERCIAL GENERAL LIABILITY					2023-05 (\$10M SIR)	06/01/2023	06/01/2024	EACH OCCURRENCE		\$ 10,000,000	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	CLAIMS MADE	<input type="checkbox"/>	OCCUR.	DAMAGE TO RENTED PREMISES (Ea occurrence)				\$			
	<input checked="" type="checkbox"/>	Medical Professional Liability			MED EXP (Any one person)					\$			
	<input type="checkbox"/>				PERSONAL & ADV INJURY					\$			
	GEN'L AGGREGATE LIMIT APPLIES PER:				GENERAL AGGREGATE					\$ 10,000,000			
	<input type="checkbox"/>	POLICY:	<input type="checkbox"/>	PRO-JECT	<input type="checkbox"/>	LOC				PRODUCTS - COMP/OP AGG		\$	
	<input type="checkbox"/>	OTHER:								\$			
	AUTOMOBILE LIABILITY								COMBINED SINGLE LIMIT (Ea accident)		\$		
	<input type="checkbox"/>	ANY AUTO			BODILY INJURY (Per person)		\$						
	<input type="checkbox"/>	OWNED AUTOS ONLY	<input type="checkbox"/>	SCHEDULED AUTOS	BODILY INJURY (Per accident)		\$						
	<input type="checkbox"/>	HIRED AUTOS ONLY	<input type="checkbox"/>	NON-OWNED AUTOS ONLY	PROPERTY DAMAGE (Per accident)		\$						
	<input type="checkbox"/>						\$						
	<input type="checkbox"/>						\$						
	<input type="checkbox"/>						\$						
	<input type="checkbox"/>	UMBRELLA LIAB		<input type="checkbox"/>	OCCUR				EACH OCCURRENCE		\$		
	<input type="checkbox"/>	EXCESS LIAB		<input type="checkbox"/>	CLAIMS-MADE				AGGREGATE		\$		
	<input type="checkbox"/>	DED	<input type="checkbox"/>	RETENTION \$							\$		
	<input type="checkbox"/>												
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				N/A				<input type="checkbox"/>	PER STATUTE	<input type="checkbox"/>	OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)								<input type="checkbox"/>	E.L. EACH ACCIDENT		\$	
	If yes, describe under DESCRIPTION OF OPERATIONS below								E.L. DISEASE - EA EMPLOYEE		\$		
											\$		
									E.L. DISEASE - POLICY LIMIT				

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)  
Evidence of Coverage

All employees of Insured are provided coverage under this policy, including residents, interns, nurse practitioners, nurse midwives, athletic trainers, physician assistants, profusionists, therapists, social workers, CRNA's podiatrists, paramedics and employed physicians while acting within the scope of their duties as such. Also covered are authorized Volunteers and facility Medical Directors while acting within the scope of their duties as such.

CERTIFICATE HOLDER	CANCELLATION
Baptist M & S Imaging, North Central Breast Center  502 Madison Oak, Suite 450 San Antonio, TX 78258	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE   Marsh Management Services Cayman Ltd.



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

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<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No,):</b>	<b>FAX (A/C, No):</b>	
	<b>E-MAIL ADDRESS:</b>		
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
<b>INSURED</b>  Baptist M & S North Central Imaging Ctr 540 Madison Oak, Ste. 160 San Antonio, TX 78258	<b>INSURER B :</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	<b>EACH OCCURRENCE</b>	\$ 10,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.		<b>DAMAGE TO RENTED PREMISES (Ea occurrence)</b>				\$	
	<input checked="" type="checkbox"/> Medical Professional Liability		<b>MED EXP (Any one person)</b>				\$	
			<b>PERSONAL &amp; ADV INJURY</b>				\$	
	GEN'L AGGREGATE LIMIT APPLIES PER:		<b>GENERAL AGGREGATE</b>				\$ 10,000,000	
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC		<b>PRODUCTS - COMP/OP AGG</b>				\$	
	OTHER:						\$	
	<b>AUTOMOBILE LIABILITY</b>						<b>COMBINED SINGLE LIMIT (Ea accident)</b>	\$
	<input type="checkbox"/> ANY AUTO						<b>BODILY INJURY (Per person)</b>	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						<b>BODILY INJURY (Per accident)</b>	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						<b>PROPERTY DAMAGE (Per accident)</b>	\$
								\$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR						<b>EACH OCCURRENCE</b>	\$
	<b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE						<b>AGGREGATE</b>	\$
	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> N						<b>E.L. EACH ACCIDENT</b>	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						<b>E.L. DISEASE - EA EMPLOYEE</b>	\$
								\$
							<b>E.L. DISEASE - POLICY LIMIT</b>	

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**

see below

For Insurance Verification Purposes

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**CERTIFICATE HOLDER****CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Marsh Management Services Cayman Ltd.

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

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<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No,):</b>	<b>FAX (A/C, No):</b>	
	<b>E-MAIL ADDRESS:</b>		
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
<b>INSURED</b>  Baptist M & S Imaging Northeast 8815 Village Drive San Antonio, TX 78217	<b>INSURER B :</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		


**COVERAGES**                      **CERTIFICATE NUMBER:**                      **REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	EACH OCCURRENCE	\$ 10,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
	<input checked="" type="checkbox"/> Medical Professional Liability						MED EXP (Any one person)	\$
							PERSONAL & ADV INJURY	\$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	\$ 10,000,000
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG	\$
	OTHER:						\$	
	<b>AUTOMOBILE LIABILITY</b>						COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person)	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						BODILY INJURY (Per accident)	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$
								\$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR						EACH OCCURRENCE	\$
	<b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE						AGGREGATE	\$
	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> N		N/A				E.L. EACH ACCIDENT	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	\$
								\$
							E.L. DISEASE - POLICY LIMIT	

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**  
Evidence of Coverage

All employees of Insured are provided coverage under this policy, including residents, interns, nurse practitioners, nurse midwives, athletic trainers, physician assistants, profusionists, therapists, social workers, CRNA's podiatrists, paramedics and employed physicians while acting within the scope of their duties as such. Also covered are authorized Volunteers and facility Medical Directors while acting within the scope of their duties as such.

<b>CERTIFICATE HOLDER</b>  Baptist M & S Imaging Northeast 8815 Village Drive San Antonio, TX 78217	<b>CANCELLATION</b> SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.  <b>AUTHORIZED REPRESENTATIVE</b>   Marsh Management Services Cayman Ltd.
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

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<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No,):</b>		<b>FAX (A/C, No):</b>
	<b>E-MAIL ADDRESS:</b>		
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
<b>INSURED</b>  Baptist M & S Northeast MRI/CT Center 8815 Village Drive San Antonio, TX 78217	<b>INSURER B :</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		


**COVERAGES**                      **CERTIFICATE NUMBER:**                      **REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE			ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS					
A	X	COMMERCIAL GENERAL LIABILITY					2023-05 (\$10M SIR)	06/01/2023	06/01/2024	EACH OCCURRENCE		\$ 10,000,000		
	X	CLAIMS MADE		OCCUR.	DAMAGE TO RENTED PREMISES (Ea occurrence)					\$				
	X	Medical Professional Liability			MED EXP (Any one person)					\$				
					PERSONAL & ADV INJURY					\$				
	GEN'L AGGREGATE LIMIT APPLIES PER:				GENERAL AGGREGATE					\$ 10,000,000				
		POLICY:		PRO-JECT		LOC				PRODUCTS - COMP/OP AGG		\$		
		OTHER:								\$				
	AUTOMOBILE LIABILITY								COMBINED SINGLE LIMIT (Ea accident)		\$			
		ANY AUTO							BODILY INJURY (Per person)		\$			
		OWNED AUTOS ONLY		SCHEDULED AUTOS					BODILY INJURY (Per accident)		\$			
		HIRED AUTOS ONLY		NON-OWNED AUTOS ONLY					PROPERTY DAMAGE (Per accident)		\$			
											\$			
		UMBRELLA LIAB			OCCUR				EACH OCCURRENCE		\$			
		EXCESS LIAB			CLAIMS-MADE				AGGREGATE		\$			
		DED		RETENTION \$							\$			
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below				N/A						PER STATUTE		OTH-ER	
										E.L. EACH ACCIDENT		\$		
										E.L. DISEASE - EA EMPLOYEE		\$		
												\$		
										E.L. DISEASE - POLICY LIMIT				

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**  
see below

For Insurance Verification Purposes Effective  
All employees of Insured are provided coverage under this policy, including residents, interns, nurse practitioners, nurse midwives, athletic trainers, physician assistants, profusionists, therapists, social workers, CRNA's podiatrists, paramedics and employed physicians while acting within the scope of their duties as such. Also covered are authorized Volunteers and facility Medical Directors while acting within the scope of their duties as such.

<b>CERTIFICATE HOLDER</b>  Baptist M & S Northeast MRI/CT Center 8815 Village Drive San Antonio, TX 78217	<b>CANCELLATION</b>  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.  <b>AUTHORIZED REPRESENTATIVE</b>    Marsh Management Services Cayman Ltd.
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

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<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No,):</b>		<b>FAX (A/C, No):</b>
	<b>E-MAIL ADDRESS:</b>		
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
<b>INSURED</b>  Baptist M & S Imaging and PET Center 8435 Wurzbach Road, Ste 109 San Antonio, TX 78229	<b>INSURER B :</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	<b>EACH OCCURRENCE</b>	\$ 10,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.		<b>DAMAGE TO RENTED PREMISES (Ea occurrence)</b>				\$	
	<input checked="" type="checkbox"/> Medical Professional Liability		<b>MED EXP (Any one person)</b>				\$	
			<b>PERSONAL &amp; ADV INJURY</b>				\$	
	GEN'L AGGREGATE LIMIT APPLIES PER:		<b>GENERAL AGGREGATE</b>				\$ 10,000,000	
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC		<b>PRODUCTS - COMP/OP AGG</b>				\$	
	OTHER:						\$	
	<b>AUTOMOBILE LIABILITY</b>						<b>COMBINED SINGLE LIMIT (Ea accident)</b>	\$
	<input type="checkbox"/> ANY AUTO						<b>BODILY INJURY (Per person)</b>	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						<b>BODILY INJURY (Per accident)</b>	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						<b>PROPERTY DAMAGE (Per accident)</b>	\$
								\$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR						<b>EACH OCCURRENCE</b>	\$
	<b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE						<b>AGGREGATE</b>	\$
	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> N						<b>E.L. EACH ACCIDENT</b>	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						<b>E.L. DISEASE - EA EMPLOYEE</b>	\$
								\$
							<b>E.L. DISEASE - POLICY LIMIT</b>	

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**

see below

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AUTHORIZED REPRESENTATIVE

Marsh Management Services Cayman Ltd.

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

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<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No, E-MAIL ADDRESS:</b>		<b>FAX (A/C, No):</b>
	<b>INSURER(S) AFFORDING COVERAGE</b>		
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
	<b>INSURER B :</b>		
<b>INSURED</b>  Baptist M&S Imaging & Schertz 16977 I-35 North, Suite 220 Schertz, TX 78154	<b>NAIC #</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		


**COVERAGES** **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	EACH OCCURRENCE	\$ 10,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
	<input checked="" type="checkbox"/> Medical Professional Liability						MED EXP (Any one person)	\$
							PERSONAL & ADV INJURY	\$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	\$ 10,000,000
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG	\$
	OTHER:						\$	
	<b>AUTOMOBILE LIABILITY</b>						COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person)	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						BODILY INJURY (Per accident)	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$
								\$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR						EACH OCCURRENCE	\$
	<b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE						AGGREGATE	\$
	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						PER STATUTE	OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> N						E.L. EACH ACCIDENT	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	\$
								\$
							E.L. DISEASE - POLICY LIMIT	

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**  
see below

All employees of Insured are provided coverage under this policy, including residents, interns, nurse practitioners, nurse midwives, athletic trainers, physician assistants, profusionists, therapists, social workers, CRNA's podiatrists, paramedics and employed physicians while acting within the scope of their duties as such. Also covered are authorized Volunteers and facility Medical Directors while acting within the scope of their duties as such.

<b>CERTIFICATE HOLDER</b>  Baptist M&S Imaging & Schertz 16977 I-35 North, Suite 220 Schertz, TX 78154	<b>CANCELLATION</b> SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.  <b>AUTHORIZED REPRESENTATIVE</b>   Marsh Management Services Cayman Ltd.
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/25/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an **ADDITIONAL INSURED**, the policy(ies) must have **ADDITIONAL INSURED** provisions or be endorsed. If **SUBROGATION** IS **WAIVED**, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b>  Tenet Healthcare 14201 N. Dallas Parkway Dallas, TX 75254	<b>CONTACT NAME:</b>		
	<b>PHONE (A/C, No,):</b>	<b>FAX (A/C, No):</b>	
	<b>E-MAIL ADDRESS:</b>		
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
<b>INSURED</b>  Baptist M & S Imaging - Westover 3903 Wiseman Blvd. #101 San Antonio, TX 78251	<b>INSURER B :</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		


**COVERAGES**                      **CERTIFICATE NUMBER:**                      **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			2023-05 (\$10M SIR)	06/01/2023	06/01/2024	EACH OCCURRENCE	\$ 10,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
	<input checked="" type="checkbox"/> Medical Professional Liability						MED EXP (Any one person)	\$
							PERSONAL & ADV INJURY	\$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	\$ 10,000,000
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG	\$
	OTHER:						\$	
	<b>AUTOMOBILE LIABILITY</b>						COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person)	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						BODILY INJURY (Per accident)	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$
								\$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR						EACH OCCURRENCE	\$
	<b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE						AGGREGATE	\$
	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> N						E.L. EACH ACCIDENT	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	\$
								\$
							E.L. DISEASE - POLICY LIMIT	

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**  
see below

All employees of Insured are provided coverage under this policy, including residents, interns, nurse practitioners, nurse midwives, athletic trainers, physician assistants, profusionists, therapists, social workers, CRNA's podiatrists, paramedics and employed physicians while acting within the scope of their duties as such. Also covered are authorized Volunteers and facility Medical Directors while acting within the scope of their duties as such.

<b>CERTIFICATE HOLDER</b>  Baptist M & S Imaging - Westover 3903 Wiseman Blvd #101 San Antonio, TX 78251	<b>CANCELLATION</b> SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.  <b>AUTHORIZED REPRESENTATIVE</b>   Marsh Management Services Cayman Ltd.
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## TEXAS LIABILITY INSURANCE CARD

COMPANY PHONE NO.  
844-620-2818

COMPANY



COMM'L



PERSONAL



NAMED DRIVER POLICY

National Union Fire Insurance Company of Pittsburg

POLICY NUMBER  
4594321

EFFECTIVE DATE  
6/1/2023

EXPIRATION DATE  
6/1/2024

YEAR MAKE

Any Auto Driven By the Insured

MODEL

VEHICLE IDENTIFICATION NUMBER

AGENCY

Arthur J. Gallagher Risk Management Services, LLC  
500 N Brand Boulevard, Suite 100  
Glendale, CA 91203

AGENCY PHONE NO.

818-539-2300

NAME AND ADDRESS OF INSURED

Tenet Healthcare Corp.  
14202 N. Dallas Parkwa  
Dallas, TX 75254

This policy provides at least the minimum amounts of liability insurance required by the Texas Motor Vehicle Safety Responsibility Act for the specified vehicles and named insureds and may provide coverage for other persons and vehicles as provided by the insurance policy.

635823

## SPANISH TRANSLATION

## TRADUCCION DE ESPANOL

**Tarjeta de Seguro de Responsabilidad Civil de Texas**  
**Guarde esta tarjeta.**

**IMPORTANTE:** Usted debe mostrar esta tarjeta o una copia de su póliza de seguro cuando solicite o renueve su:

- (A) Registro del vehículo motorizado
- (B) Licencia de conducir
- (C) Etiqueta de inspección de seguridad para su vehículo.

También se puede pedir que usted muestre esta tarjeta o su póliza si tiene un accidente o si se la pide un oficial de policía.

Todos los conductores en Texas deben tener un seguro de responsabilidad civil para sus vehículos, o de lo contrario deben cumplir con los requisitos legales de responsabilidad financiera. Si usted no cumple con los requisitos de responsabilidad financiera, podría estar sujeto a pagar una multa de hasta \$1,000, mas la suspensión de su licencia de conducir y la suspensión del registro del vehículo, y además su vehículo podría ser confiscado por hasta 180 días (a un costo de \$15 por día).

ACORD 50 TX (2020/01)

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**TEXAS LIABILITY INSURANCE CARD**

**Keep this card.**

**IMPORTANT:** You must show this card or a copy of your insurance policy when you apply for or renew your:

- (A) Motor vehicle registration
- (B) Driver's License
- (C) Motor vehicle safety inspection sticker.

You also may be asked to show this card or your policy if you have an accident or if a peace officer asks to see it.

All drivers in Texas must carry liability insurance on their vehicles or otherwise meet legal requirements for financial responsibility. If you do not meet your financial responsibility requirements, you could be fined up to \$1,000, your driver's license and motor vehicle registration could be suspended, and your vehicle could be impounded for up to 180 days (at a cost of \$15 per day).

**IMPORTANTE:** Si usted desea una tarjeta oficial de comprobante de seguro escrita en español, comuníquese con su agente de seguros a este número:

Company Phone No. : 844-620-2818

ACORD 50 TX (2020/01)

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	<b>E-MAIL ADDRESS:</b>		
	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A :</b> The Healthcare Insurance Corporation		
<b>INSURED</b>  Orthopedic and Neurologic Imaging Institute 4103 N. Loop 1604 West, Suite 107 San Antonio, TX 78249	<b>INSURER B :</b>		
	<b>INSURER C :</b>		
	<b>INSURER D :</b>		
	<b>INSURER E :</b>		
	<b>INSURER F :</b>		

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	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR.		<b>DAMAGE TO RENTED PREMISES (Ea occurrence)</b>				\$	
	<input checked="" type="checkbox"/> Medical Professional Liability		<b>MED EXP (Any one person)</b>				\$	
			<b>PERSONAL &amp; ADV INJURY</b>				\$	
	GEN'L AGGREGATE LIMIT APPLIES PER:		<b>GENERAL AGGREGATE</b>				\$ 10,000,000	
	<input type="checkbox"/> POLICY: <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC		<b>PRODUCTS - COMP/OP AGG</b>				\$	
	OTHER:						\$	\$
	<b>AUTOMOBILE LIABILITY</b>						<b>COMBINED SINGLE LIMIT (Ea accident)</b>	\$
	<input type="checkbox"/> ANY AUTO						<b>BODILY INJURY (Per person)</b>	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						<b>BODILY INJURY (Per accident)</b>	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						<b>PROPERTY DAMAGE (Per accident)</b>	\$
								\$
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	DED <input type="checkbox"/> RETENTION \$							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> N						<b>E.L. EACH ACCIDENT</b>	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						<b>E.L. DISEASE - EA EMPLOYEE</b>	\$
								\$
							<b>E.L. DISEASE - POLICY LIMIT</b>	

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**  
Evidence of Coverage

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