Cigna

Exhibit A-2

Fee Schedule and Reimbursement Terms
For Loading Purposes

This is an Exhibit to an Agreement between:
Provider: Beth Israel Lahey Health Performance Network
Cigna Party: Cigna Health and Life Insurance Company
Effective Date of Base Agreement: October 1, 2021

This Rate Exhibit:
Applies to: Beth Israel Lahey Health Performance Network on behalf of Beth Israel Deaconess Medical Center, Inc.
Federal Tax ID: 042103881
National Provider Identifier: 1548202641
Effective Start Date: October 1, 2022 Effective End Date: September 30, 2023

Payor will pay Hospital in accordance with the fee schedule and the reimbursement terms set forth herein for Covered Services rendered to Participants. Except where otherwise indicated, Cigna may adjust coding in its systems to remain consistent with the parties' intent to reimburse for the services listed in this Exhibit.

I. Inpatient Services

Hospital shall accept as full and final payment for all Covered Services provided to Participants who are admitted as inpatients the reimbursement specified in this Exhibit. Such reimbursement covers all inpatient Covered Services, including but not limited to, semi-private room and board, operating room, the services of Hospital-Based Physicians employed by or compensated by Hospital, nurses and other Hospital employees and permitted subcontractors, all supplies excluding personal convenience items, laboratory management and interpretation of test results, all ancillary services, pharmacy, and other Medically Necessary services provided to a Participant. Payor shall deduct any Copayments, Deductibles, or Coinsurance required by the Benefit Plan from payment due to Hospital. References to DRG's in the inpatient chart below shall mean MS-DRG's. If the MS DRGS are modified such that the DRGs are no longer defined as below the Parties agree to amend the Agreement so that the rates of payment for the services paid at the Case Rates remain at the same levels set forth in this Agreement.

Inpatient Service Descriptions	Coding	Reimbursement

Medical/Surgical -Adult and Pediatric	Revenue Codes in the 100-169 revenue code range unless specified below or specifically excluded from this exhibit	$6,705.64 Per Diem

ICU/CCU including Medical, Surgical, Cardiac and Pediatric	Revenue Codes: 200, 201, 202, 203, 207, 208, 209, 210, 211, 212, 219	$7,237.50 Per Diem
Intermediate ICU/CCU	Revenue Codes: 206, 214	$7,237.50 Per Diem

Vaginal Delivery – Mother Only	MS-DRG Codes: 768, 796, 797, 798, 805, 806, 807	$3,644.03 Per Diem
C-Section Delivery – Mother Only	MS-DRG Codes: 783, 784, 785, 786, 787, 788	$3,644.03 Per Diem
Newborn Level I (Normal/Boarder)	Revenue Codes: 170, 171, 179	$979.46 Per Diem
Newborn Level II (Premature)	Revenue Code: 172	$1,401.79 Per Diem
Newborn Level III (Sick Neonate)	Revenue Code: 173	$2,941.55 Per Diem
Newborn Level IV (NICU)	Revenue Code: 174	$4,903.64 Per Diem

Rehabilitation Unit	Revenue Codes: 118, 128, 138, 148, 158	Services not available as of contract effective date. If service becomes available, Section III. E. applies.

Sub Acute Level I	Revenue Codes: 190, 191, 199	Services not available as of contract effective date. If service becomes available, Section III. E. applies.
Sub Acute Level II	Revenue Code: 192	Services not available as of contract effective date. If service becomes available, Section III. E. applies

Sub Acute Level III	Revenue Code: 193	Services not available as of contract effective date. If service becomes available, Section III. E. applies.
Sub Acute Level IV	Revenue Code: 194	Services not available as of contract effective date. If service becomes available, Section III. E. applies.

Detoxification Unit	Revenue Codes: 116, 126, 136, 146, 156	Services not available as of contract effective date. If service becomes available, Section III. E. applies.

Hospice	Revenue Codes: 115, 125, 135, 145, 155, 656	Services not available as of contract effective date. If service becomes available, Section III. E. applies.

Transplants		Reimbursed under Cigna Lifesource contract if applicable

Inpatient DRG

Inpatient DRG Service Description and Code	Inpatient DRG Reimbursement	Inpatient DRG Reimbursement Type	DRG Outlier Day (Day Case Rate is Paid Through)	Inpatient DRG Outlier Day Reimbursement	Inpatient DRG Outlier Day Reimbursement Type
MS-DRG 216, CARDIAC VALVE W CARD CAT W MCC	$ 154,468.90	Case Rate	25	$ 6,705.64	Per Diem
MS-DRG 217, CARDIAC VALVE W	$ 104,849.03	Case Rate	25	$ 6,705.64	Per Diem

CARD CAT W CC					
MS-DRG 218, CARD VALVE W CAR CTH WO CC/MCC	$ 82,125.45	Case Rate	25	$ 6,705.64	Per Diem
MS-DRG 219, CARD VALVE W CAR CTH W CC/MCC	$ 124,562.59	Case Rate	19	$ 6,705.64	Per Diem
MS-DRG 220, CARD VALVE W CAR CTH WO CC/CC	$ 82,886.90	Case Rate	19	$ 6,705.64	Per Diem
MS-DRG 221, CARD VALVE W CAR CTH WO CC/MCC	$ 69,040.65	Case Rate	19	$ 6,705.64	Per Diem
MS-DRG 222, CRD DEF IMP W AMI/HF/SK W MCC	$ 131,340.91	Case Rate	20	$ 6,705.64	Per Diem
MS-DRG 223, CRD DEF IMP W AMI/HF/SK WO MCC	$ 99,010.16	Case Rate	20	$ 6,705.64	Per Diem
MS-DRG 224, CRD DEF IMP WO AMI/HF/SK W MCC	$ 116,838.51	Case Rate	25	$ 6,705.64	Per Diem
MS-DRG 225, CRD DF IMP WO AMI/HF/SK WO MCC	$ 92,774.23	Case Rate	20	$ 6,705.64	Per Diem
MS-DRG 226, CAR	$ 99,410.37	Case Rate	20	$ 6,705.64	Per Diem

DEFB MPLT WO CAR CAT W MCC					
MS-DRG 227, CAR DEF IMPL WO CAR CAT WO MCC	$ 80,034.87	Case Rate	20	$ 6,705.64	Per Diem
MS-DRG 228, OTH CARDIOTH ORACIC PROCS W MCC	$ 116,935.41	Case Rate	20	$ 6,705.64	Per Diem
MS-DRG 229, OTH CARDIOTH ORACIC PROCS W/O MCC	$ 73,576.73	Case Rate	20	$ 6,705.64	Per Diem
MS-DRG 231, CORONARY BYPASS W PTCA W MCC	$ 121,095.50	Case Rate	20	$ 6,705.64	Per Diem
MS-DRG 232, CORONARY BYPASS W PTCA W/O MCC	$ 89,661.01	Case Rate	20	$ 6,705.64	Per Diem
MS-DRG 233, CORONARY BYP W CARD CATH W MCC	$ 111,078.63	Case Rate	20	$ 6,705.64	Per Diem
MS-DRG 234, COR BYPASS W CARD CATH WO MCC	$ 74,403.48	Case Rate	20	$ 6,705.64	Per Diem

MS-DRG 235, COR BYPASS WO CARD CATH W MCC	$ 90,194.98	Case Rate	20	$ 6,705.64	Per Diem
MS-DRG 236, COR BYPASS WO CARD CATH WO MCC	$ 58,107.51	Case Rate	12	$ 6,705.64	Per Diem
MS-DRG 242, PERM CARD PCMKR IMPLANT W MCC	$ 57,444.00	Case Rate	15	$ 6,705.64	Per Diem
MS-DRG 243, PERM CARDIAC PCMKR IMPLNT W CC	$ 40,849.98	Case Rate	10	$ 6,705.64	Per Diem
MS-DRG 244, PERM CARD PCMKR IMPL WO CC/MCC	$ 31,433.43	Case Rate	10	$ 6,705.64	Per Diem
MS-DRG 245, AICD GENERATO R PROCS	$ 65,471.40	Case Rate	10	$ 6,705.64	Per Diem
MS-DRG 246, PERC CARD PX W DG EL ST W MCC	$ 49,006.92	Case Rate	15	$ 6,705.64	Per Diem
MS-DRG 247, PERC CARD PX W DG EL ST WO MCC	$ 30,344.44	Case Rate	10	$ 6,705.64	Per Diem
MS-DRG 248, PERC CAR PX W	$ 45,073.26	Case Rate	15	$ 6,705.64	Per Diem

N-DG EL ST W MCC					
MS-DRG 249, PER CAR PX W N-DG EL ST WO MCC	$ 27,326.00	Case Rate	10	$ 6,705.64	Per Diem
MS-DRG 250, PER CAR PX WO ST OR AMI W MCC	$ 44,436.09	Case Rate	15	$ 6,705.64	Per Diem
MS-DRG 251, PER CAR PX WO ST OR AMI WO MCC	$ 27,725.16	Case Rate	10	$ 6,705.64	Per Diem
MS-DRG 268, AORT HRT ASST PROC EX PULSE BALL/W MCC	$ 105,472.52	Case Rate	21	$ 6,705.64	Per Diem
MS-DRG 269, AORT HRT ASST PROC EX PULS BALL W/OMCC	$ 52,845.78	Case Rate	11	$ 6,705.64	Per Diem
MS-DRG 270, OTHER MAJOR CARDIOVA SCULAR PROC W MCC	$ 79,983.27	Case Rate	21	$ 6,705.64	Per Diem
MS-DRG 271, OTHER MAJOR CARDIOVA SCULAR PROC W CC	$ 54,630.94	Case Rate	16	$ 6,705.64	Per Diem
MS-DRG 272, OTR MAJOR CARDIOVA	$ 40,389.74	Case Rate	16	$ 6,705.64	Per Diem

SC PROC W/O CC/MCC					
MS-DRG 273, PERCUTANEOUS INTRACARDIAC PROC W MCC	$ 75,419.80	Case Rate	16	$ 6,705.64	Per Diem
MS-DRG 274, PERCUTANEOUS INTRACARDIAC PROC W/O MCC	$ 50,660.43	Case Rate	11	$ 6,705.64	Per Diem
MS-DRG 286, CIRC DSRD EX AMI,W CA CA W MCC	$ 30,841.54	Case Rate	10	$ 6,705.64	Per Diem
MS-DRG 287, CIRCULAT DIS, W CAR CAT WO MCC	$ 16,764.64	Case Rate	7	$ 6,705.64	Per Diem
MS-DRG 837, CHEM W AC LEUK AS SDX OW HI D CHE WMCC	$ 102,631.02	Case Rate	na	$0.00	Per Diem
MS-DRG 838, CHE W A LEUK AS SDX WCC OR HI D CHE AG	$ 48,428.72	Case Rate	na	$0.00	Per Diem

A. Inpatient Exclusions
If Hospital's total Billed Charges for a revenue code listed in the chart below for Covered Services rendered with respect to a particular Participant's continuous inpatient confinement exceed the threshold referenced in the chart below, Hospital shall be reimbursed separately for such revenue code as specified in the chart below,

less applicable Copayments, Coinsurance and Deductibles. Hospital's total Billed Charges for the revenue codes listed in the chart below will be excluded from any and all Hospital stop loss calculations including but not limited to deducting these charges from the overall Billed Charges in determining the stop loss threshold.

Hospital attests that its reimbursement for the revenue codes listed in the chart below will approximately reflect the invoice cost to Hospital for such revenue codes. Cigna reserves the right to request an audit of Hospital's charge master against Hospital's invoice cost and to adjust the percentage reduction from Billed Charges to the extent that the reimbursement to Hospital for such revenue codes exceeds the invoice cost to Hospital.

Prosthetics and Orthotics	Revenue Code: 274	Threshold for each revenue code: $6,165.00 Reimbursement: 50 % Reduction from Billed Charges

Pacemaker Supplies	Revenue Code: 275	Threshold for each revenue code: $6,165.00 Reimbursement: 50 % Reduction from Billed Charges

Implants	Revenue Code: 278	Threshold for each revenue code: $6,165.00 Reimbursement: 50 % Reduction from Billed Charges

Intraocular Lens	Revenue Code: 276	Threshold for each revenue code: $6,165.00 Reimbursement: 50% Reduction from Billed Charges

B. Stop Loss

1. Notwithstanding the foregoing, if Hospital's Billed Charges for Covered Services rendered with respect to a particular Participant's continuous acute inpatient confinement exceed $128,675.88 (the "Threshold"), Hospital will be reimbursed for Covered Services rendered to such Participant at the rates specified above less

applicable Copayments, Coinsurance and Deductibles, through the date the Threshold is met (the "Threshold Date"), and at $7,553.46 or to inpatient services paid at the per diem rates for Newborn Levels I-IV.

2. Hospital shall only be entitled to the additional reimbursement provided pursuant to this stop loss provision if, within 180 days after the date of the applicable Participant's discharge from Hospital or within 30 days from Cigna's request to Hospital, Hospital provides Cigna with an itemized bill for its total Billed Charges for Covered Services rendered through the Threshold Date and through the date of discharge with respect to the applicable Participant.

II. Outpatient Services

Hospital shall accept as full and final payment for all Covered Services provided to Participants on an outpatient basis the reimbursement specified in this Exhibit. Such reimbursement covers all outpatient Covered Services, including but not limited to, all facility services, the services of all Hospital-Based Physicians employed by or compensated by Hospital, nurses and other Hospital employees and permitted subcontractors, laboratory management and interpretation of test results, ancillary, diagnostic, and pharmacy charges, and other Medically Necessary services provided in relation to the outpatient categories specified below. The applicable rate includes all Medically Necessary services that Hospital customarily provides to outpatients. Payor shall deduct any Copayments, Deductibles, or Coinsurance required by the Benefit Plan from payment due to Hospital.

Outpatient Services	**Coding**	**Reimbursement**
Ambulatory Surgery	Revenue Codes: 360, 361, 369, 490, 499, 750, 761, 790 unless specified below	30.7 % Reduction from Billed Charges

Cardiac Catheterization Lab Services	Revenue Code: 481	30.7 % Reduction from Billed Charges

Hip Replacement	CPT4 Codes: 27125, 27130, 27132, 27134, 27137, 27138	$18,700.50 Case Rate

Observation	Revenue Code: 762	$5,020.54 Per Stay

Knee Replacement	CPT4 Codes: 27412, 27415, 27438, 27445, 27446, 27447, 27486, 27487	$18,700.50 Case Rate

Fusion	CPT4 Codes: 22551, 22554, 22633, 62380	$18,700.50 Case Rate

Allograft for Spine Surgery only; morselized	CPT4 Codes: 20930	$12,330.00 Case Rate

Cervical Artificial Diskectomy	CPT4 Codes: 22856	$18,700.50 Case Rate

Emergency Department Services	Revenue Codes: 450, 451, 452, 459	30.7 % Reduction from Billed Charges
Urgent Care	Revenue Code: 456	30.7 % Reduction from Billed Charges

Urgent Care Services (Free Standing)	Revenue Codes: 516, 526	30.7 % Reduction from Billed Charges

Clinic Visit**	Revenue Codes: 510-515; 517; 519; 520-525; 527-529	$104.14 Per Visit

Chemotherapy Administration Services	Revenue Codes: 331, 332, 335	30.7 % Reduction from Billed Charges

Radiation Therapy Services	Revenue Code: 333	30.7% Reduction from Billed Charges

CT/CTA Scan(s) includes contrast materials and other radiologic supplies and all of the same scan type billed for that day.	Revenue Codes: 350, 351, 352, 359	$1,024.75 Per Visit

MRI/MRA Scan(s) includes contrast materials and other radiologic supplies and all of the same scan type billed for that day.	Revenue Codes: 610, 611, 612, 614, 615, 616, 618, 619	$1,769.36 Per Visit

PET Scan(s) includes contrast materials and other radiologic supplies and all of the same scan type billed for that day.	Revenue Code: 404	$2,476.04 Per Visit

Nuclear Medicine Scan(s)	Revenue Codes: 340, 341, 342, 349	30.7% Reduction from Billed Charges

Radiology Services not otherwise listed herein	CPT4 Codes: 70000-79999, 93880, 93882, 93886, 93888, 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93970, 93971, 93975, 93976, 93978, 93979, 93980, 93981, 93985, 93986, 93990 All applicable CPT4 Category III T codes All applicable HCPCS codes	251% of Cigna Market Fee Schedule

Clinical and Anatomical Laboratory Services	CPT4 Codes: 36410, 36415, 36416, 80000-89999 All applicable HCPCS codes	204 % of Cigna Market Fee Schedule

Physical Therapy	Revenue Codes: 420, 421, 422, 423, 424, 429	$147.53Per Visit
Occupational Therapy	Revenue Codes: 430, 431, 432, 433, 320, 439	$147.53 Per Visit
Speech Therapy	Revenue Codes: 440, 441, 442, 443, 444, 449	$147.53 Per Visit
Respiratory Therapy	Revenue Codes: 410, 412, 419	$147.53 Per Visit
Dialysis	Revenue Codes: 821, 831, 841, 851	30.7 % Reduction from Billed Charges
Fetal Non Stress Test	CPT4 Code: 59025	30.7 % Reduction from Billed Charges
Amniocentesis	CPT4 Codes: 59000, 59001	30.7 % Reduction from Billed Charges
Ambulance service, conventional air services, transport, one way (rotary wing)	HCPCS Code: A0431	No reimbursement; Provider may not bill Participant
All Other Outpatient Covered Services	Revenue Codes not otherwise listed above	30.7 % Reduction from Billed Charges

A. Outpatient Exclusions

If Hospital's total Billed Charges for a code listed in the chart below for Covered Services rendered with respect to a particular Participant's outpatient service exceed the threshold referenced in the chart below, Hospital shall be reimbursed separately for such code as specified in the chart below, less applicable Copayments, Coinsurance and Deductibles.

Hospital attests that its reimbursement for the codes listed in the chart below will reflect the invoice cost to Hospital for such codes. Cigna reserves the right to request an audit of Hospital's charge master against Hospital's invoice cost and to adjust the percentage reduction from Billed Charges to the extent that the reimbursement to Hospital for such codes exceeds the invoice cost to Hospital.

Prosthetics and Orthotics	Revenue Code: 274	Threshold for each revenue code: $6,165.00 Reimbursement: 50 % Reduction from Billed Charges

Pacemaker Supplies	Revenue Code: 275	Threshold for each revenue code: $6,165.00 Reimbursement: 50 % Reduction from Billed Charges

Implants	Revenue Code: 278	Threshold for each revenue code: $6,165.00 Reimbursement: 50 % Reduction from Billed Charges

Intraocular Lens	Revenue Code: 276	Threshold for each revenue code: $6,165.00 Reimbursement: 50% Reduction from Billed Charges

For services/supplies listed in the chart below, Provider shall be reimbursed separately for such services/supplies as specified, less applicable Copayments, Coinsurance and Deductibles. Provider's total Billed Charges for the services/supplies listed in the chart below will be excluded from any and all calculations of reimbursement for the episode of care however will be based upon the lesser of billed charges or contract rate.

Injectable drugs not otherwise listed herein	All applicable injectable CPT4 and HCPCS codes	163 % Cigna Market Fee Schedule or 30.7 % Reduction from Billed Charges if no fee available on Cigna Market Fee Schedule

*Per visit rate means the flat rate applicable to a particular type of service, such as therapeutic, rehabilitative or diagnostic services, and all codes associated with that type of service performed on the same day.

**Clinic Visit will replace/terminate the "Confidential Release of All Claims and Settlement Agreement", effective March 2004.

**Clinic Visit (Revenue codes listed above): Clinic Visit services will be reimbursed at the agreed upon rate as specified in the Rate Exhibit, all other ancillary services on the day of the clinic visit will be reimbursed according the reimbursement specified in the Rate Exhibit.

III. Miscellaneous Terms

A. Chargemaster Increases

1. Notification of Chargemaster Increases. Hospital shall provide Cigna with thirty-(30) days prior written notice via letter signed by Hospital's Chief Financial Officer (or other responsible officer of Hospital) should any charges increase during the term of this Agreement. Hospital will also provide Cigna with an electronic file of Hospital's new chargemaster list at that time. The electronic file will contain the following data split between inpatient and outpatient chargemaster codes: a) all chargemaster codes and descriptions; b) total number of charge units provided to Participants under this Agreement during the most recent calendar year; c) chargemaster unit prices in effect; and d) UB revenue/CPT codes. Upon request, Hospital shall furnish Cigna with an electronic file of Hospital's chargemaster list containing the data elements specified above on the Effective Date of this Agreement, and annually thereafter.
2. Adjustment to Reimbursement Rates. Any increase for a given reimbursement amount(s) in excess of 3 percent during any 12-month period of this Agreement may result in an adjustment to the reimbursement rate(s). The reimbursement amount(s) may be changed appropriately to ensure that Payor's reimbursement to Hospital for a given service does not increase by more than 3 percent during any twelve month period of this Agreement. If applicable, any stop loss or exclusion threshold may also be adjusted by the amount by which Hospital's chargemaster has increased in excess of 3 percent since the Effective Date of this Agreement.
3. Right to Audit. Cigna shall have the right to audit Hospital's records relating to Hospital's billed charges in order to assure compliance with and to enforce this provision. Cigna may also audit its records relating to Hospital's billed charges. If audit findings indicate a change in billed charges, Cigna shall notify Hospital of such findings, any adjustments to the percentage discount and stop loss and exclusion thresholds, and the effective date of such adjustments.

B. When a Participant is admitted as an inpatient after receiving outpatient services on the same calendar day, or when 2 or more Primary Services are performed on the same calendar day, the following Payment Rules apply:

When one of the Primary Services listed are performed, all Covered Services will be reimbursed at the applicable Payment Rule rate.

When no Primary Services are performed, reimbursement for Covered Services will be at the individual rate associated with the service as listed in this Exhibit.

Primary Service	Payment Rule
Ambulatory Surgery with MRI, CT or PET Scan	Ambulatory Surgery rate and MRI, CT or PET scan rates apply

Ambulatory Surgery with Observation	Ambulatory Surgery and Observation rates both apply
Ambulatory Surgery transfer to Inpatient	Inpatient rate(s) applies only
Emergency Department Services with or transfer to Ambulatory Surgery	Ambulatory Surgery and Emergency Department Services rates both apply
Emergency Department Services with or transfer to Observation	Observation and Emergency Department Services rates both apply
Emergency Department Services with or transfer to Cardiac Catheterization Lab Services	Cardiac Catheterization Lab Services rate applies only
Emergency Department Services with MRI, CT or PET Scan	Emergency Department Services and MRI, CT or PET scan rates apply
Emergency Department Services transfer to Inpatient	Inpatient rate(s) applies only
Observation with MRI, CT or PET Scan	Observation and MRI, CT or PET scan rates apply
Observation transfer to Inpatient	Inpatient rate(s) applies only
Observation with or transfer to Cardiac Catheterization Lab Services	Cardiac Catheterization Lab Services rate applies only
Cardiac Catheterization Lab Services with MRI, CT or PET Scan	Cardiac Catheterization Lab Services and MRI, CT, or PET scan rates apply
Cardiac Catheterization Lab Services with Cardiac Catheterization Procedures or PTCA and Other Percutaneous Cardiac Procedures	Cardiac Catheterization Procedures or PTCA and Other Percutaneous Cardiac Procedures rate applies only
Cardiac Catheterization Procedures with PTCA and Other Percutaneous Cardiac Procedures	PTCA and Other Percutaneous Cardiac Procedures rate applies only
Cardiac Catheterization Lab Services transfer to Inpatient	Inpatient rate(s) applies only
Any other outpatient service that converts to an inpatient admission	Inpatient rate(s) applies only

Under no circumstances will the reimbursement of Medically Necessary observation care exceed the inpatient medical per diem. If the primary reason for admission from the ambulatory surgery facility is associated with Hospital's scheduling or administrative procedures, the ambulatory surgery rate will apply.

C. Hospital's reimbursement for its costs pertaining to a Participant's diagnostic testing and procedures occurring within 3 days of an elective admission or ambulatory surgery is included in the compensation for inpatient or outpatient services set forth above.

D. Intentionally Deleted.

E. New inpatient or outpatient services or technology are not included in the above rates and shall be reimbursed at 60% of Hospital's billed charges in effect at that time of services until such time in which Cigna and Hospital agree upon a rate for such service or new technology. Hospital shall provide Cigna with at least (30) days advance written notice of new technology or service.

F. Reimbursement for in-patient and/or out-patient services covered by a Participant's mental health/substance abuse benefit plan will be according to Hospital's agreement with Cigna Behavioral Health, as applicable.

G. The applicable reimbursement rate for Covered Services shall be that rate applicable to the level of care which is Medically Necessary notwithstanding the level of care actually provided.

H. Intentionally Deleted

I. Intentionally Deleted

J. The parties acknowledge they have agreed upon an aggregate rate increase of 2.5% year one, 2.75% year two, and 3% year three. The parties also acknowledge that while the rates set forth above are intended to reflect that agreed upon increase, System has not had the opportunity to fully validate the application of such increases. To that end, should either party, within 14 calendar days after the Effective Date of this Agreement, identify a discrepancy in the application of the aggregate rate and/or specific language presented above, the parties agree to amend this Agreement and reprocess impacted claims in order to correct such discrepancy(cies).