EXHIBIT A.2

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

MONTEFIORE MEDICAL CENTER, MONTEFIORE NEW ROCHELLE HOSPITAL, MONTEFIORE MOUNT VERNON HOSPITAL, MONTEFIORE NYACK HOSPITAL, ST. LUKE'S CORNWALL HOSPITAL, WINIFRED M. BURKE REHAB HOSPITAL, and WHITE PLAINS HOSPITAL MEDICAL CENTER,

Plaintiffs,

-against-

AETNA HEALTH INC., and AETNA HEALTH INSURANCE COMPANY OF NEW YORK,

Defendants.

SUMMONS WITH NOTICE

Index No. 811188/2021E

Date Index No. Purchased: 8-17-2021

To the Person(s) Named as Defendant(s) above:

PLEASE TAKE NOTICE THAT YOU ARE HEREBY SUMMONED to appear in this action by serving a notice of appearance on the plaintiffs at the address set forth below, and to do so within 20 days after the service of this Summons (not counting the day of service itself), or within 30 days after service is complete if the summons is not delivered personally to you within the State of New York.

YOU ARE HEREBY NOTIFIED THAT should you fail to answer or appear, a judgment will be entered against you by default for the relief demanded below.

The nature of this action is as follows:

1. Beginning in as early as 1991, Defendants (collectively, "Aetna") entered into various contracts with the Plaintiffs, all of which are healthcare providers that are presently part of

the Montefiore Health System (collectively, "Montefiore"). In exchange for Montefiore's provision of medical services to Aetna's members, Aetna agreed to pay Montefiore for its services at rates set forth in the contracts.

2. Beginning in and around 2007, several Medicaid Managed Care Organizations ("MCOs") hired a third party consultant, Health Management Systems, Inc. ("HMS"), to audit their paid claims.

3. Because Medicaid dollars trace their source to state and federal governments, Medicaid is ordinarily a "payer of last resort," and the MCOs frequently audit claims to ensure that Medicaid dollars are not being spent on any claim that should be paid by a commercial insurer, like Aetna.

4. These audits are not unusual, as there are a number of scenarios where a healthcare provider might inadvertently bill an MCO when a commercial carrier, like Aetna, is primarily liable.

5. One common example occurs when a patient covered by an MCO obtains new employment and receives commercial coverage. In this scenario, it will take time for the MCO to discover the new coverage and, when it does, the MCO will retroactively dis-enroll the patient.

6. In the interim, however, the MCO may have processed and paid several claims, with both the MCO and the provider unaware that a third party was responsible for payment. This is only one of several reasons why a provider and an MCO might be unaware of coverage by a commercial insurer when a claim is billed and paid.

7. As a practical matter, Montefiore does not and – despite due diligence – cannot know with certainty why Aetna was not immediately identified as the responsible payor for the claims at issue here.

8. In the ordinary course, upon discovering that a patient's coverage has changed such that commercial insurance is the responsible primary payer instead of the MCO, the MCO demands repayment of the amounts that it paid on the claims from Plaintiffs.

9. Plaintiffs then bill the commercial insurance carrier for the claims at the rates in their respective contracts with the commercial insurance carrier. This process, known as coordination of benefits, results in the MCO receiving a refund for the amount that it paid before Plaintiffs or the MCO became aware of the commercial insurance coverage.

10. Coordination of benefits also allows Plaintiffs to bill the commercial insurance carriers at its negotiated contract rates for the claims that were refunded to the MCOs, or will be refunded to the MCOs upon receipt of the payment from the commercial carrier. The rates paid by MCOs are typically tied to the Medicaid rates and are substantially lower than those paid by commercial insurance carriers.

11. After auditing the MCOs claims, HMS discovered Aetna's liability for many Montefiore claims that had been paid by the MCOs. What should have occurred next was that the MCOs should have alerted Montefiore to the fact that Aetna was the responsible primary payer so that Montefiore could bill Aetna for its services at the Montefiore/Aetna contract rates, and then reimburse the MCOs for the claims they had inadvertently paid.

12. Rather than engage in the usual coordination of benefits, Aetna reimbursed the MCOs *directly* for the amounts that the MCOs had paid Montefiore on the claims. When it paid the MCOs, however, Aetna paid only the Medicaid rate that had been paid by the MCOs for Montefiore's services. The Medicaid rate is substantially lower than the rates that Montefiore and Aetna agreed to in the contracts between them.

13. Worse, Aetna remained entirely silent about having reimbursed the MCOs directly, meaning that Aetna simply kept the difference between the low Medicaid rate it paid the MCOs and the higher contractual rate it was required to pay Montefiore, based on the contracts.

14. This secret direct-payment scheme deprived Montefiore of millions of dollars in commercial insurance reimbursement that it was entitled to under its contracts with Aetna.

15. Plaintiff Montefiore Medical Center (MMC) discovered this scheme in or about 2016, only as it related to another commercial payor, not Aetna. MMC sued that payor and was successful and, in the course of that litigation, subpoenaed HMS' records.

16. HMS' records, recently received by Montefiore, have revealed that Aetna has also engaged in this direct-payment scheme in an effort to deprive Montefiore of its contractual payment on claims.

17. This direct-payment scheme was hidden from Montefiore by Aetna because it created a windfall to Aetna, which only paid the Medicaid rate instead of the contractually negotiated rates it actually owed to Montefiore.

18. Additionally, Aetna hid this scheme from Montefiore in order to induce Montefiore to enter into several new agreements with Aetna that were favorable to Aetna, but that would never have been signed had Aetna not hidden this conduct from Montefiore.

19. Thus Aetna had knowledge of a material fact that it concealed to induce Montefiore to sign new agreements in Aetna's favor, which Montefiore did in ignorance of the direct-payment scheme, to its detriment.

20. Many commercial insurers like Aetna also pay into the "Public Goods Pool" established under the New York Health Care Reform Act ("HCRA"). HCRA surcharges are used to fund health care initiatives and care for the indigent within the state. Upon information and

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