CROWN CASTLE USA INC

Prescription Drug Program

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Administered by Express Scripts

Crown Castle USA Inc
Prescription Drug Program

Page

About Your Benefits.....3

Prescription Drug Coverage.....4

How the Prescription Drug Plan Works..... 5

The Retail Program..... 7

The Home Delivery Pharmacy Service.....7

Specialty Pharmacy.....9

General Plan Provisions.....10

Prescription Drugs Not Covered (Exclusions).....11

Claims Filing.....13

Appeals Procedure.....15

Other Administrative Information.....24

This document is a component of your Crown Castle USA Inc. medical benefit coverage summary plan description "SPD." Please keep this document with your medical coverage documents.

About Your Benefits

About this Booklet

This booklet describes the prescription drug benefits available to participants in the medical coverage options sponsored by Crown Castle USA Inc.

This booklet is considered part of the summary plan description ("SPD") for your Crown Castle medical benefit coverage. Please keep this booklet with your medical coverage documents. Your SPD serves as one of the official plan documents for your benefits, so please read this information carefully.

Your medical and prescription drug benefits are offered through the Crown Castle USA Inc. Welfare Benefit Plan.

This Plan is self-insured, meaning that benefits are paid by Crown Castle USA Inc. and affiliated entities (collectively the “Company”). The costs of this Plan are paid by the Company.

Eligibility

Your eligibility for benefits under this prescription drug plan, and the eligibility of your dependents, is determined by your eligibility for a medical plan. The eligibility rules are discussed in detail in your medical coverage SPD.

If you and your dependents are enrolled in one of Crown Castle's medical plans, you are eligible to participate in this program.

When Coverage Begins

Coverage for you and your dependents begins on the same day your coverage begins under your Crown Castle medical coverage. Refer to the medical coverage documents for more details on when coverage begins.

Cost

Coverage under the prescription drug program is provided at no additional cost to you if you enroll in one Crown Castle's medical benefit coverage options. The cost for coverage under the Crown Castle medical program includes coverage for this prescription drug program.

Identification Cards

After you enroll in one of Crown Castle's medical benefit programs (currently Traditional Plan, HSA Plus Plan and HSA Base Plan) which includes participation in this prescription drug program, you will receive an identification card for the prescription drug program. The prescription drug information is incorporated into your medical ID card. You will not receive a

separate card for prescription drug coverage.

Prescription Drug Coverage

Your prescription drug coverage is designed to provide financial protection for you and your covered dependents against the cost of prescription drugs. This booklet describes the prescription drug program and what it can mean to you and your family. The first part describes the benefits available and the second part provides detailed information on how to use the plan. Remember, these benefits are considered part of your Crown Castle medical benefit coverage; important information about your benefits is located in your medical coverage SPD. Please note that there are no benefits for out of network pharmacies.

The chart below highlights the prescription drug coverage:

There are no benefits for out of network pharmacies	**Traditional Plan**		**HSA Plus**		**HSA Base**	
	Network		**Network**		**Network**	
	30-Day Supply (Retail)	**90 Day Supply (Mail/Smart90)**	**30 Day Supply (Retail)**	**90 Day Supply (Mail/Smart90)**	**30 Day Supply (Retail)**	**90 Day Supply (Mail/Smart90)**
Generic	**$10 Co-pay**	**$20 Co-pay**	**10% after deductible; $25 max**	**10% after deductible; $50 max**	**$0 after deductible**	**$0 after deductible**
Preferred Brand	**$30 Co-pay**	**$60 Co-pay**	**20% after deductible; $75 max**	**20% after deductible; $150 max**	**$0 after deductible**	**$0 after deductible**
Non-preferred Brand	**$50 Co-pay**	**$100 Co-pay**	**30% after deductible; $150 max**	**30% after deductible; $300 max**	**$0 after deductible**	**$0 after deductible**
Preventative Drugs	**Same as above**	**Same as above**	**No charge**	**No charge**	**No charge**	**No charge**

Mandatory Generic: You are responsible for the payment differential when a brand name drug is authorized by you or the provider and a generic is available. Your payment is the cost difference between the brand name drug and generic drug plus the non-preferred brand copay (if applicable) not to exceed the total cost of the brand name drug.

Certain ACA preventive drugs and services may be covered at 100% as required by federal law. A complete up-to-date list can be found at www.express-scripts.com. Network restrictions may apply.

In additional to the ACA preventative drugs, the HSA Plus and HSA Base plans cover certain preventive drugs before the deductible is met. Refer to the Preventive Drug listing for specific details.

This is a brief description of the prescription drug program. While prescription drugs that are "medically necessary" are covered, there are restrictions that apply to this program. (Consult the medical SPD to learn more about which drugs and services are considered medically necessary.) It is important that you review the material in the following pages of this booklet to become thoroughly familiar with your prescription drug coverage. In addition to describing the benefits, the limitations and non-covered items are explained. You can obtain information on which drugs are generic, preferred and non-preferred by calling Express Scripts at **1-855-778-1431** or on the internet at www.express-scripts.com. Additionally, important information about other aspects of your combined medical/prescription drug coverage is set forth in your medical program SPD.

Annual Deductible

There is a combined annual deductible for your medical and prescription drug expenses for the HSA Plus and HSA Base Plans (see Prescription Drug Coverage Table for amounts).

For the eligible HSA option, the Plan does not begin reimbursing prescription drug expenses until you have met the deductible. This means that you must meet your deductible before the Plan begins reimbursing prescription drug expenses unless your prescription is for select preventive prescription drugs in which the deductible does not apply. Any penalties, like extra costs you pay for a brand-name prescription drug when a generic is available, filling maintenance drug for a 30-day supply at a retail pharmacy after the allowed two fills or filling prescription drugs out of network, do not count toward your deductible.

For the Traditional Plan, you do not need to meet a deductible before your plan begins paying for your prescription drug expenses.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum caps your expenses in a calendar year. All expenses, including those incurred under the Express Scripts pharmacy benefit apply to a combined medical and pharmacy out-of-pocket. For detailed information on the combined medical and prescription out-of-pocket maximum, limits by plan and coverage tier, what applies, and how it works please refer to your Medical Summary Plan Description.

How the Prescription Drug Program Works

In general, the program works as outlined below if you use a participating retail pharmacy or the Express Scripts' Home Delivery Pharmacy:

- **Retail** You can purchase up to a 30-dayday supply of prescription drugs at an Express Scripts participating retail pharmacy. You can also purchase up to a 90-day supply of your maintenance

prescription drugs at a CVS or Walgreens retail pharmacy. This is referred to as the **Smart90 Program.** If you do not use a participating pharmacy, you will pay the full cost of the drug as benefits are not paid for prescriptions filled at a non-participating pharmacy.

- **Home Delivery Pharmacy** You can purchase up to a 90-day supply of long-term medications taken regularly for chronic conditions, such as high blood pressure, asthma, diabetes or high cholesterol. This type of prescription is also referred to as a maintenance drug (those drugs taken on an ongoing basis) through the Express Scripts Home Delivery Pharmacy**.**

Covered Prescription Drug Expense

The prescription drug program provides benefits only for covered prescription drug expenses. Covered expenses are those related to the diagnosis and treatment of an illness or injury. Prescriptions or supplies must be medically necessary, prescribed by a doctor who is qualified under the terms of your Crown Castle medical coverage, available only with a prescription, and not excluded from coverage by this plan. See Prescription Drugs Not Covered (Exclusions) section for a list of excluded expenses.

In some situations, your doctor may write a prescription for a drug that is available without a prescription or one that can be purchased over-the-counter (OTC). These nonprescription drugs are not covered under the Crown Castle prescription drug program.

The Retail Program

Using the Retail Program

Express Scripts has contracted with over 64,000 retail pharmacies, including most major drug stores. These retail pharmacies in the Express Scripts network are referred to as “in-network” and “participating pharmacies.” To locate a participating pharmacy close to your home or other location, you can call Express Scripts Patient Customer Service at 1-855-778-1431 or check the Express Scripts website at www.Express-Scripts.com. You can purchase up to a 30-day supply at any participating retail pharmacy. **Maintenance prescription drugs will be required to be filled through Express Scripts Pharmacy for Home Delivery, a CVS retail pharmacy or a Walgreens retail pharmacy after two fills.** Maintenance prescription drugs filled at a 30-day supply after two fills will be subject to 100% member cost share of the discounted prescription drug cost (this is considered a penalty).

The below describes the process of how to use your prescription benefits at a participating retail pharmacy.

At a participating network pharmacy
1. Present your ID card to your pharmacist along with your prescription each time you have a prescription filled or refilled. 2. Pay the pharmacist any applicable co-payment or coinsurance amounts. 3. The plan will pay the rest. There are no claim forms to complete

If you do not show your ID card when you obtain a prescription from a participating pharmacy, you will be charged the regular price for the prescription, not the negotiated rate. This will cost you more than if you had presented your card.

Express Scripts Pharmacy for Home Delivery and Mandatory Smart90 Program

You are required to fill maintenance prescription drugs for a 90-day supply through the Express Scripts Pharmacy for Home Delivery or at any CVS or Walgreens retail pharmacy location.

Using Home Delivery

Express Scripts offers the Express Scripts Pharmacy Home Delivery program to fill your maintenance prescription drugs (for up to a 90-day supply) through Home Delivery. When you use the Express Scripts Pharmacy, you can get a larger supply of your prescription drug at a lower cost than what you would pay for filling the same medication at a 30-day supply for three continuous months at a retail pharmacy; and you will save yourself multiple trips to the pharmacy. You will also have the convenience of having your

prescription drugs delivered right to you. It only takes a few minutes to set it up the first time. After that, you can order refills online easily.

Using the Smart90 Program

You may also fill a 90-day supply of your prescription drugs through the Mandatory Smart90 program at any CVS or Walgreens retail pharmacies. Mandatory Smart90 allows you two 30-day courtesy fills at any network retail pharmacy before a penalty is triggered. Once you have used your courtesy fills, you must switch to a 90-day supply at a CVS or Walgreens pharmacy or pay 100% of the prescription drug cost.

Using the Express Scripts Pharmacy Home Delivery Program for the First Time

First-time users of the Express Scripts Home Delivery Pharmacy can sign up for the program either online or by telephone. To register online:

- Log in to www.Express-Scripts.com and select “Register Now”
- Complete the information requested, including personal information and member ID number, and create a username and password
- Click “Register now” and you’re registered
- To order a prescription, select “Order Prescriptions” under the “Manage Prescriptions” tab

To register for the program by telephone:

- Call Express Scripts at 1-855-778-1431
- Speak with a Patient Customer Service representative who will help you with your request.

You should receive your prescription drugs within seven to 10 days of when your order is placed.
If you would like to use the Express Scripts Home Delivery Pharmacy, you may want to ask your doctor to write you a prescription for up to a 30-day supply of medication to be filled at a retail pharmacy and one for up to a 90-day supply to be filled through the Express Scripts Pharmacy so that you have medication on hand while your home delivery prescription is being filled. You may also bring your 90-day prescription to any CVS or Walgreens retail pharmacy.

Refilling Prescriptions Using the Express Scripts Pharmacy for Home Delivery Program

You can have your prescription drugs refilled online or by phone with Home Delivery. Be sure to reorder your prescription at least three weeks before you expect to run out of your prescription drug. If you miss this deadline, you may ask your doctor to write you a prescription for up to a 30-day supply of your prescription drug to be filled at a retail pharmacy while you wait for your prescription drug from the Express Scripts Pharmacy Home Delivery program.

You can also use the free Express Scripts mobile app to refill prescriptions, check order status, view alerts, and locate pharmacies and more. Download from the App Store or Google Play.

Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist. If you have any questions about your prescription order, please call Express Scripts number:

1-855-778-1431

Express Scripts Specialty Pharmacy

Some drugs, such as self-injectables and oral drugs, have specific storage and handling requirements. Accredo is the exclusive pharmacy under the Express Scripts prescription drug program for providing specialty medications. Accredo will give you personalized medication management, education materials and social support services at no additional cost. Some specialty medications will require that you fill them at Accredo even on your first prescription while others may allow you to fill at your retail pharmacy twice before requiring you to have them filled at Accredo.

If you are not sure if your prescription qualifies as a specialty drug, you and/or physician may call:

Accredo Customer Service
866-759-1557
8AM to 8:00 PM (Eastern time) Monday through Friday.

SaveOnSP

Specialty medications can cost a lot of money. SaveOnSP helps lower your out-of-pocket costs for certain eligible specialty medications to $0 by using copay assistance.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of their out-of-pocket costs for certain medications. SaveOnSP is a program designed to help members save money on certain eligible specialty medications by taking advantage of funds available through drug manufacturers in order to lower the member's out-of-pocket costs to $0.

If you're filling an eligible specialty medication, an Express Scripts representative can help you enroll in the program. If you choose to participate in SaveOnSP, you'll pay $0 for your medication. If you choose not to participate in SaveOnSP, you'll pay a higher cost when you fill your medication.

Certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's deductible and out-of-pocket maximum. Although the cost of the Program drugs will not be applied towards satisfying a participant's deductible and out-of-pocket maximum, the cost of the Program drugs will be reimbursed by the manufacturer at no cost to the participant.

Conditions covered by SaveOnSP include, but are not limited to:

- Hepatitis C
- Multiple Sclerosis
- Psoriasis
- Rheumatoid Arthritis
- Inflammatory Bowel Disease

- Cancer

To obtain a full list of specialty medications eligible under the SaveOnSP program, please visit www.saveonsp.com/crowncastleusa or contact SaveOnSP at 1-800-683-1074.

General Provisions

What Is the Difference between Generic, Preferred Brand-Name Drugs and Non-preferred Brand-Name Drugs?

The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs go through the same FDA approval process as their brand-name equivalents. They are considered safe, cost-effective and, in most cases, can be substituted for brand names. When you get a prescription, you may want to ask your doctor if you may use generic substitutes.

Formulary Preferred brand-name drugs are brand-name drugs that are preferred by your plan. This list includes a wide selection of medications and is preferred because it offers you choice while helping keep the cost of your prescription drug benefit affordable. Each drug is Food and Drug Administration (FDA) approved and reviewed by an independent group of doctors and pharmacists for safety and efficacy.

Some Non-preferred brand-name drugs are not covered on the plan's formulary.

Formulary
If you would like information concerning the current Express Scripts formulary you can review this information at www.express-scripts or by calling the Express Scripts customer service number at (855) 778-1431.

Mandatory Generic
You are responsible for the payment differential when a brand name drug is authorized by you or the provider and a generic is available.

Other Provisions
The prescription drug program includes several provisions which focus on clinical management of pharmacy care. They include safety review, retrospective safety review, dose optimization, quantity limits, step therapy and Interactive Saving tools. The below provisions could affect getting your prescription filled under this plan.

Maximum Supply of Prescription Drugs: A prescription filled through a retail pharmacy can dispensed for a 30-day through 90-day supply dependent upon the prescription written by your physician. Refills are limited to your doctor's specifications for up to one year (by federal law).

For maintenance drugs, a supply of up to 90 days must be obtained through a CVS or Walgreens retail pharmacy using the Smart90 program or through home delivery service. Refills for maintenance drugs are also limited to your doctor's specifications for up to one year.

For specialty drugs, a supply of up to 90 days with Accredo's Clinical Day Supply Program may be allowed however new therapies may require members to start with a 30-day supply to stabilize on the medication before moving to a 90-day supply.

Prior Authorization: Certain prescriptions will require a prior authorization by your physician in order for the prescription to be filled and covered under the plan. A prior authorization is a defined set of circumstances by which a drug may be covered under a benefit. Express Scripts uses criteria developed to ensure safe, effective and appropriate utilization of selected drugs. Your prescribing physician must confirm that the patient has met the selected evidence-based criteria in order to obtain and override coverage for the selected drug and for the claim to be paid under the plan. The list of drugs requiring prior authorization is subject to change periodically. To determine if your medication is subject to prior authorization contact Express Scripts customer service.

Quantity Limits: Some drugs have quantity limits to encourage appropriate usage and ensure effectiveness. The quantity limit is the maximum amount of a drug that can be dispensed over a given period of time. If you require a greater quantity than allowed by the plan, you and your doctor can request a review via the prior authorization and appeals process. Drug lists and clinical evaluations are continuously being evaluated. To discuss how your drug could be impacted by Quantity limits or other clinical edits please contact Express Scripts customer service.

Step Therapy: This edit manages prescription-drug waste within specific therapy classes by guiding patients to first-line medications before "stepping up" to more costly second-line medications. Within specific therapy classes, several clinically effective medications are often available to treat the same condition. Step Therapy takes advantage of these opportunities to direct a patient to a clinically effective, lower-cost medication. Evidence-based clinical protocols for each step therapy module ensure patients receive cost-effective drug therapy that is clinically appropriate for their condition. Our Step Therapy program minimizes impact to members at the point of sale by applying automation to reject claims only for members whose history does not show use of first-line products.

Prescription Drugs Not Covered (Exclusions)

In addition to limitations mentioned in other parts of this booklet, the plan does not provide prescription drug benefits for the following. These exclusions include, but are not limited to:

- **Drugs that can be purchased over the counter without a prescription, even if your doctor writes a prescription**
- **Drugs that are not medically necessary, as that term is defined in your medical plan**

- **Replacement of lost, stolen, or damaged drugs**
- **Drugs dispensed for cosmetic purposes including hair loss drug such as Rogaine® for hair growth (topical minoxidil), anti-wrinkle creams, hair removal creams and others**
- **Drugs or insulin while confined to a hospital, nursing home, or similar home, which are billed as part of your inpatient medical charges**
- **Expenses payable under any other company benefit plan**
- **Drugs dispensed by the prescribing doctor**
- **Experimental drugs or drugs labeled "Caution—Limited by Federal Law to Investigational Use"**

Experimental Drugs Not Covered

Experimental drugs are medications that have not been approved by the Food and Drug Administration (FDA). Experimental medications do not have NDC numbers and therefore are not covered.

In some cases, these medications are used by doctors who are selected by the manufacturer of the drug during human clinical trials. The doctors choose the patients who participate in the trials. In most cases, the drug manufacturer will fund the entire cost of the program, including the cost of the medication.

- **Therapeutic devices or appliances, including support garments, ostomy supplies, durable medical equipment**
- **Healing devices, immunization agents, organic serum, blood, or blood plasma**
- **Vitamins or health and beauty aids**
- **Delivery charges in conjunction with the participating retail pharmacy network**
- **Drug expenses for one person which are incurred in order to treat an injury or sickness of a different person, no matter which person incurs the expense (for example, an organ transplant/donation)**
- **Drugs for which no charge is made or no payment would be required if you did not have this coverage**
- **Drugs furnished or payable under a plan or program operated by a national government or one of its agencies**
- **Drugs furnished or payable under a state cash sickness or similar law, including any group insurance policy approved under such law**
- **Drugs used to treat injury or illness resulting from an act of war (declared or undeclared), insurrection, atomic explosion, or other release of nuclear energy (except when used solely as medical treatment) or in connection with military service**
- **Drugs used to treat injury or illness resulting from taking part in an assault or a felony**

- **Drugs used to treat illness covered by Workers' Compensation, occupational disease law, or similar laws**
- **Drugs used to treat injury if it arises out of employment for pay, profit or gain**
- **Expenses incurred before coverage begins or after coverage ends**

Claims Filing

When you have your prescription filled at a participating retail pharmacy, there are no claim forms to complete. Simply present your benefit ID card at the time of purchase along with your co-payment.

There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. On behalf of the Plan, Express Scripts will make a determination for each type of prescription drug benefit claim within the time periods described below. Prescription drug claims are subject to specific rules that differ slightly from medical benefit claims, so you should review this section carefully when you have an issue regarding a prescription drug benefit.

Please note that when you present your benefit I.D. at a retail pharmacy, you are not treated as making a "claim" for benefits for purposes of these rules. If the retail pharmacy refuses to fill the prescription unless you pay 100% of the prescription price, the retail pharmacy's decision is not considered a claim for benefits. If you pay the charge and then submit a claim for reimbursement to Express Scripts, the submitted claim will be treated as your initial claim for benefits and processed under the "Post-Service Claim" rules described below (since you would have paid for and received your prescription). If you refuse to pay the charges and instead submit a claim to Express Scripts, your submission to Express Scripts will be treated as your initial claim for benefits and processed under the "Pre-Service Claim" or "Urgent Care Claim" rules described below.

Pre-Service Claim

A Pre-Service Claim is a claim for a prescription drug benefit that requires approval in advance of obtaining the benefit. A request for prior authorization is an example of a Pre-Service Claim.

A Pre-Service Claim determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim. An extension of fifteen (15) days is permitted if Express Scripts determines that, for reasons beyond the control of Express Scripts, an extension is necessary. If an extension is necessary, Express Scripts will notify you within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date Express Scripts expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. You will have at least forty-five (45) days to provide the required information. If Express Scripts does not receive

the required information within the forty-five (45) day time period, the claim will be denied. Express Scripts will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If Express Scripts receives the requested information after the forty-five (45) days, but within 225 days, the initial claim will be denied and upon receipt of the requested information, the claim will be reviewed as a first level appeal. Reference the section entitled “Appeals Procedures” below for details regarding the appeals process.

If a Pre-Service Claim is improperly filed, or otherwise does not follow applicable procedures, you will be sent notification within five (5) days of receipt of the claim.

Urgent Care Claim

An Urgent Care Claim is any pre-service claim for a prescription drug benefit that has to be decided more quickly because using the normal timeframes for decision-making could: 1) seriously jeopardize your life or health or your ability to regain maximum function, or 2) in the opinion of a physician with knowledge of your condition, subject you to severe pain that cannot be adequately managed without the prescription drug benefit that is the subject of your claim.

An Urgent Care Claim determination will be sent to you in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

If your Urgent Care Claim is determined to be incomplete, you will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. You will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

If you request an extension of Urgent Care Benefits beyond an initially determined period and make the request at least twenty-four (24) hours prior to the expiration of the original determination period, you will be notified within twenty-four (24) hours of receipt of the request for an extension.

Post-Service Claim

A Post-Service Claim is a claim for a prescription drug benefit after you have already received the benefit. A request for reimbursement for amounts you paid for a prescription drug is an example of a Post-Service Claim.

A Post-Service Claim determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim. An extension of fifteen (15) days may be necessary if Express Scripts (on behalf of the Plan) determines that, for reasons beyond the control of Express Scripts, an extension is necessary. If an extension is necessary, Express Scripts will notify you within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date Express Scripts expects to render a determination. If the

extension is necessary to request additional information, the extension notice will describe the required information. You will have at least forty-five (45) days to provide the required information. If Express Scripts does not receive the required information within the forty-five (45) day time period, the claim will be denied. Express Scripts will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If Express Scripts receives the requested information after the forty-five (45) days, but within 225 days, the initial claim will be denied and upon receipt of the requested information, the claim will be reviewed as a first level appeal. Reference the section entitled “Appeals Procedures” below for details regarding the appeals process.

Concurrent Care Claim

A Concurrent Care Claim is a claim involving a pre-approved, ongoing prescription drug benefit. A Concurrent Care Claim arises when Express Scripts, on behalf of the Plan, determines that your benefit should be reduced or terminated, or you request an extension of the benefit. You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow you time to appeal the decision before the benefits are reduced or terminated.

Notice of Determination

If your claim is filed properly, and the claim is in part or wholly denied, the claim decision is considered an “Adverse Benefit Determination” and you will receive a notice that will:

- State the specific reason(s) for the Adverse Benefit Determination;
- Reference the specific Plan provisions on which the determination is based;
- Describe additional material or information, if any, needed to complete the claim and
- the reasons such material or information is necessary;
- Describe the claims review procedures and the time limits applicable to such
- procedures, including a statement of your right to bring a civil action under section
- 502(a) of ERISA following an Adverse Benefit Determination on review;
- Disclose any internal rule, guideline, or protocol relied on in making the Adverse
- Benefit Determination (or state that such information is available free of charge upon request); and,
- If the reason for denial is based on a lack of Medical Necessity or Experimental and Investigational Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

Appeals Procedure

To initiate an appeal, you must submit a request for an appeal in writing to Express Scripts within

180 days after you receive the claim denial from Express Scripts (or after you receive Express Scripts' initial response to your complaint or other dispute). If Express Scripts' initial decision to deny your claim involves an urgent care claim, you may request an expedited review of the decision (either orally or in writing) as described in the sections entitled "Urgent Care Claims". To initiate an appeal through Express Scripts, write to:

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63166-6588

Alternatively, you may fax your written appeal to Express Scripts at 1-877-852-4070.
If Express Scripts determines that your written appeal contains new, additional information that Express Scripts did not have when it initially reviewed and responded to your claim, the plan provides a two-step appeals procedure for your pharmacy benefits claim denial, complaint or other dispute. Under this two-step appeals procedure, Express Scripts will review and respond to your first appeal as a reconsideration of its initial claims decision, as described below. If Express Scripts again denies your claim, you may submit a second written appeal to have your claim reviewed by an independent, third-party appeals administrator, who will review and respond to your second appeal as described below.

However, if Express Scripts determines that your written appeal does not contain any new, additional information regarding your original claim, the plan provides only a one-step appeals procedure, and Express Scripts will promptly forward your written appeal directly to the independent, third-party appeals administrator, who will review and respond to your appeal as described below.

When reviewing your appeal of a claim denial, complaint or other dispute in either a one-step or two-step appeal procedure, Express Scripts and the appeals administrator will apply the following standards.

- You may submit written comments, documents, records, and other information relating to the claim for benefits, and Express Scripts and/or the appeals administrator will take all of such information into account when reviewing your claim, without regard to whether such information was submitted or considered during Express Scripts' initial benefit determination or prior review on appeal;

- You may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information that is relevant to your claim for benefits (as determined by Express Scripts and/or the appeals administrator, in its sole discretion);

- Express Scripts' and/or the appeals administrator's review of your claim will not give any deference to Express Scripts' initial review and claim denial or any prior appeal review. The review will be conducted by an individual who was not involved in any previous review of your claim, and this individual will not be the subordinate of any individuals involved in any previous review of your claim;

- If your claim or complaint is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is an experimental, investigational or unproven service or not medically necessary or appropriate, Express Scripts and/or the appeals administrator will consult with a health care professional who was not involved in the initial determination or prior review on appeal and who has appropriate training and experience in the applicable field of medicine. Express Scripts and/or the appeals administrator may consult with, or seek the participation of, medical experts as part of the appeal process. By submitting an appeal, you consent to this referral and the sharing of pertinent medical claim information; and

- Upon your request, Express Scripts and/or the appeals administrator will identify the names of any medical or vocational experts whose advice was obtained in connection with the initial or subsequent review denial of your claim, without regard to whether the advice of such experts was relied upon by Express Scripts in making its decision.

Two-Step Appeals Procedure

Level-One Appeal

If your appeal contains new, additional information and the two-step appeals procedure applies to you, Express Scripts will conduct the initial Level-One appeal review and reconsider your claim on the basis of the new, additional information you submitted. Express Scripts will notify you of its decision on review of your appeal or complaint as follows:

Urgent Care Claims. If you or the provider of services believes that a delay in treatment could (a) seriously jeopardize your life or health or your ability to regain maximum function, or (b) in the opinion of a *physician* with knowledge of your health condition, cause you severe pain which cannot be managed without the requested *pharmacy benefits*, you do not need to submit your appeal in writing. Either you or your *physician* should call Express Scripts as soon as possible by calling (844) 595-4151.

- Express Scripts will notify you in writing of its decision on the review of your appeal or complaint within 72 hours after receiving your appeal or notice of complaint or other dispute.

- Express Scripts may provide an *urgent care* decision to you and your *physician* orally (by telephone), or in writing or electronically (by fax, email or other expedited means) within 72 hours. Any oral notifications will be followed within 3 days by a written or electronic notification.

- Express Scripts' timeframe for making a benefit determination may not be extended. However, if you do not provide all of the relevant information Express Scripts needs to make a decision when you submit your appeal or complaint, your appeal or complaint may be denied in whole or in part.

Pre-Service Claims (Non-Urgent Care). If you file an appeal of a claim denial or a complaint with respect to benefits that must be pre-approved by Express Scripts prior to receiving *pharmacy benefits*, Express Scripts will generally notify you in writing of its decision on the review of your appeal or complaint within 15 days of receiving your appeal request or notice of complaint or other dispute. Express Scripts' timeframe for making a benefit determination may not be extended. However, if you do not provide all of the relevant information Express Scripts needs to make a decision when you submit your appeal or complaint, your appeal or complaint may be denied in whole or in part.

Post-Service Claims. If you file an appeal of a claim denial or a complaint with respect to pharmacy benefits that you have already received, Express Scripts will generally notify you in writing of its decision on the review of your appeal or complaint within 30 days after receiving your appeal request or notice of complaint or other dispute. Express Scripts' timeframe for making a benefit determination may not be extended. However, if you do not provide all of the relevant information Express Scripts needs to make a decision when you submit your appeal or complaint, your appeal or complaint may be denied in whole or in part.

Level-Two Appeal

If you are not satisfied with Express Scripts' Level-One appeal decision, you may request a second review. To initiate a Level-Two appeal, you should follow the same process required for a Level-One appeal.

For Level-Two appeals, Express Scripts will promptly forward your appeal to the appeals administrator and the appeals administrator will notify you of its decision on review of your appeal or complaint as follows:

Urgent Care Claims. If you or the provider of services believes that a delay in treatment could (a) seriously jeopardize your life or health or your ability to regain maximum function, or (b) in the opinion of a physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested pharmacy benefits, you do not need to submit your appeal in writing. Either you or your physician should call Express Scripts as soon as possible by calling (800) 417-8164. Express Scripts will promptly notify the appeals administrator of your appeal.

- The appeals administrator will notify you in writing of its decision on the review of your appeal or complaint within 72 hours after receiving your appeal or notice of complaint or other dispute.

- The appeals administrator may provide an urgent care decision to you and your physician orally (by telephone), or in writing or electronically (by fax, email or other expedited means) within 72 hours. Any oral notifications will be followed within 3 days by a written or electronic notification.

- The appeals administrator's timeframe for making a benefit determination may not be extended. However, if you do not provide all of the relevant information the appeals administrator needs to make a decision when you submit your appeal or complaint, your appeal or complaint may be denied in whole or in part.

Pre-Service Claims (Non-Urgent Care). If you file an appeal of a claim denial or a complaint with respect to pharmacy benefits that must be pre-approved by Express Scripts prior to receiving pharmacy benefits, the appeals administrator will generally notify you in writing of its decision on the review of your appeal or complaint within 15 days of receiving your appeal request or notice of complaint or other dispute. The appeals administrator's timeframe for making a benefit determination may not be extended. However, if you do not provide all of the relevant information the appeals administrator needs to make a decision when you submit your appeal or complaint, your appeal or complaint may be denied in whole or in part.

Post-Service Claims. If you file an appeal of a claim denial or a complaint with respect to pharmacy benefits that you have already received, the appeals administrator will generally notify you in writing of its decision on the review of your appeal or complaint within 30 days after receiving your appeal request or notice of complaint or other dispute. The appeals administrator's timeframe for making a benefit determination may not be extended. However, if you do not provide all of the relevant

information the appeals administrator needs to make a decision when you submit your appeal or complaint, your appeal or complaint may be denied in whole or in part.

One-Step Appeals Procedure

If your appeal does not contain any new, additional information and the one-step appeals procedure applies to you, Express Scripts will promptly forward your initial appeal to the appeals administrator and the appeals administrator will notify you of its decision on review of your appeal or complaint as follows:

Urgent Care Claims. If you or the provider of services believes that a delay in treatment could (a) seriously jeopardize your life or health or your ability to regain maximum function, or (b) in the opinion of a physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested pharmacy benefits, you do not need to submit your appeal in writing. Either you or your physician should call Express Scripts as soon as possible by calling (844) 595-4151. Express Scripts will promptly notify the appeals administrator of your appeal.

- The appeals administrator will notify you in writing of its decision on the review of your appeal or complaint within 72 hours after receiving your appeal or notice of complaint or other dispute.

- The appeals administrator may provide an urgent care decision to you and your physician orally (by telephone), or in writing or electronically (by fax, email or other expedited means) within 72 hours. Any oral notifications will be followed within 3 days by a written or electronic notification.

- The appeals administrator's timeframe for making a benefit determination may not be extended. However, if you do not provide all of the relevant information the appeals administrator needs to make a decision when you submit your appeal or complaint, your appeal or complaint may be denied in whole or in part.

Pre-Service Claims (Non-Urgent Care). If you file an appeal of a claim denial or a complaint with respect to benefits that must be pre-approved by Express Scripts prior to receiving pharmacy benefits, the appeals administrator will generally notify you in writing of its decision on the review of your appeal or complaint within 30 days of receiving your appeal request or notice of complaint or other dispute. The appeals administrator's timeframe for making a benefit determination may not be extended. However, if you do not provide all of the relevant information the appeals administrator needs to make a decision when you submit your appeal or complaint, your appeal or complaint may be denied in whole or in part.

Post-Service Claims. If you file an appeal of a claim denial or a complaint with respect to pharmacy benefits that you have already received, the appeals administrator will generally notify you in writing of its decision on the review of your appeal or complaint within 60 days after receiving your appeal request or notice of complaint or other dispute. The appeals administrator's timeframe for making a benefit determination may not be extended. However, if you do not provide all of the relevant information the appeals administrator needs to make a decision when you submit your appeal or complaint, your appeal or complaint may be denied in whole or in part.

Appeals Administrator Review

Whenever Express Scripts refers an appeal to the appeals administrator, the plan administrator delegates to the appeals administrator the complete and sole authority, discretion and responsibility for interpreting the provisions of the plan as it relates to the pharmacy benefits program, adjudicating final appeals of claims for benefits, and determining whether plan benefits are payable under the pharmacy benefits program. The appeals administrator, in its sole discretion, will make all final claims appeal determinations, and these decisions are conclusive and binding.

Notice of Claim Denial on Appeal

If your claim is denied, in whole or in part, after any review on appeal, Express Scripts and/or the appeals administrator's written or electronic notice of denial will include the following information.

- Specific reasons for the denial, including references to the specific plan provisions on which the denial is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for plan benefits;

- If applicable, a statement that you will be provided, upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in denying your claim;

- If the denial is based upon an experimental, investigational or unproven service, or a similar plan exclusion or limitation, a statement that you will be provided, upon request and free of charge, a written explanation of the scientific or clinical judgment for the claim denial, applying the terms of the plan to your medical circumstances;

- A statement of the plan's voluntary external independent review procedure, as described in the "External Independent Review Procedure" section, and a statement of your right to bring an action under ERISA Section 502(a) if your claim is denied on appeal (please note that you have this right even if you choose not to participate in the voluntary external independent review procedure described in the "External Independent Review Procedure" section below); and

- A statement that you and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the *plan* concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

External Independent Review Procedure

The following external review requirements apply to all adverse benefit determinations and final internal adverse benefit determinations other than those determinations based solely on an individual's eligibility to participate in the prescription drug program.

Standard External Review

The following procedures apply to standard external reviews:

Request for external review. You may file a request for external review within four months after receiving a notice of adverse benefit determination or final internal adverse benefit determination.

Preliminary review. The appeals administrator will complete a preliminary review of your external review request within five business days of receiving your request. The preliminary review will determine:

- Whether you were covered under the plan at the time the pharmacy benefits were requested or provided.
- Whether the adverse benefit determination relates to your failure to meet the requirements for eligibility under the plan.
- Whether you have exhausted the plan's internal appeal process or are not required to exhaust the internal appeals process.
- Whether you provided all information necessary to process your external review.

The appeals administrator will notify you in writing about the preliminary review results within one business day of completing the preliminary review. If your request is complete, but not eligible for external review (for example, because the claim relates to eligibility under the plan), the notice will describe the reason for ineligibility and provide Employee Benefit Security Administration (EBSA) contact information to allow you to discuss the issue with EBSA. If your request is not complete, the notice will describe the information needed for completion. You will be allowed to finish your request within the later of the four-month filing period or a 48-hour period following your receipt of the notice.

Referral to an Independent Review Organization (IRO). The appeals administrator will assign external reviews to an accredited IRO. To ensure independence from the plan, the appeals administrator will contract on behalf of the plan with at least three IROs and rotate claims assignments among them, or provide for random selection. IROs will not be eligible for financial incentives based on the likelihood of supporting a denial of benefits.

The appeals administrator and each IRO will enter into a contract that reflects the following:

- The IRO will use legal experts where appropriate to make coverage determinations.

- The IRO will notify you in writing of your request eligibility and acceptance for external review. The notice will state that you may submit in writing any additional information within ten business days of your receipt of the notice. The IRO may, but is not required to, accept and consider information submitted after ten business days.

- The *appeals administrator* will provide the IRO any documents and information considered in making the adverse benefit determination within five days of the assignment to the IRO. If the *appeals administrator* fails to timely provide the documents, the IRO may terminate the external review and reverse the adverse benefit determination. The IRO will notify you and the *appeals administrator* within one business day of making this decision.

- The IRO will forward to the *appeals administrator* information received from you within one business day of receipt. The *appeals administrator* may reconsider its adverse benefit

determination, but reconsideration will not delay the IRO external review. The *appeals administrator* may choose to reverse its adverse benefit determination and terminate the external review. The *appeals administrator* will notify you and the IRO of a decision to reverse the adverse benefit determination within one business day of making the decision. The IRO will terminate the external review upon receiving that notice.

- The IRO will review your claim on a de novo basis and will not be bound by or give deference to the conclusions reached during the plan's internal claims and appeals process. In addition to documents provided, the IRO will consider, if appropriate, all the following items:

  - Your medical records.
  - Reports from appropriate health care professionals.
  - Plan terms.
  - Appropriate medical practice guidelines.
  - Applicable clinical review criteria developed and used by the appeals administrator.
  - The opinion of the IRO's clinical reviewer after considering information provided.

- The IRO will provide written notice of the final external review decision to you and the appeals administrator within 45 days of receiving your request for external review.

- The IRO's decision notice will contain all the following:

  - The general description of the request for external review, including information sufficient to identify your claim (for example, the date of service, the health care provider, the claim amount, the diagnosis code and its meaning, the treatment code and its meaning, and the reason for the prior denial).
  - The date the IRO received the assignment to conduct the external review and the date of the decision.
  - References to the evidence, including the specific coverage provisions and evidence-based standards, considered in reaching the decision.
  - The principal reason for the IRO's decision, including any evidence-based standards relied on in making the decision.
  - A statement that the determination is binding, except to the extent that other remedies may be available under law to either you or the plan.
  - A statement that judicial review may be available to you.
  - Current contact information for any applicable office of health insurance consumer assistance or ombudsman.

- The IRO must maintain records of all claims and notices associated with the external review for six years. The IRO must make the records available for examination to you, the plan, or a state or federal oversight agency upon request, except where disclosure would violate privacy laws.

Reversal of decision. The plan will immediately provide coverage or payment for a claim upon receipt of an IRO decision reversing the adverse benefit determination.

Expedited External Review
The following procedures apply to expedited external reviews:

Request for expedited external review. The appeals administrator will allow you to request an expedited external review if you receive one of the following:

- An adverse benefit determination involving a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health.
- A final internal adverse benefit determination, if you have a medical condition for which the time frame for completing the standard external review would seriously jeopardize your life or health.

Preliminary review. Immediately upon receiving your request for expedited external review, the appeals administrator will determine whether the request meets the reviewability requirements for standard external review. The appeals administrator will immediately send you a notice meeting the requirements for standard external review.

Referral to IRO. Upon determining that your request is eligible for external review, the appeals administrator will assign an IRO pursuant to the same requirements used for standard external review. The appeals administrator will transmit all necessary documents and information to the IRO electronically or by any other available expeditious method. The IRO must consider the information or documents described under the procedures for standard external review. The IRO will review the claim on a de novo basis.

Notice of final external review decision. The appeals administrator's contract with the IRO will require the IRO to provide notice of a final expedited external review decision as expeditiously as your medical condition requires, but not more than 72 hours after the IRO receives your request for an expedited external review. If the notice of final decision is not in writing, the IRO must provide you and the appeals administrator written confirmation of the decision within 48 hours of providing the notice of final decision.

Legal Action
You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review and the outcome of the appeals procedure. In most instances, you may not initiate a legal action against the plan until you have completed either the one-step appeal procedure, or both the Level-One and Level-Two appeal processes under the two-step appeals procedure, as applicable, and exhausted all of your administrative remedies under the plan. However, if your appeal is expedited in the case of an urgent care claim, there is no need to complete the Level-Two process under the two-step appeals procedure prior to bringing legal action. A legal action must be brought within one year of the date that you exhaust the mandatory claims and appeal process described in this document.

You or the plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office. You may also contact the plan administrator. Consult the medical SPD for contact information for the plan administrator.

Other Administrative Information

When Coverage Ends

Your coverage ends on the same date on which your general medical plan coverage ends. Consult your medical coverage SPD for more information about when your coverage will end. The medical SPD also includes a description of COBRA and other plan provisions that may permit you to continue coverage.

Coordination of Benefits

The Prescription Drug Program does not include a coordination of benefits provision. This means that payments from this benefit are not coordinated with those you are entitled to receive from other plans. If you are a current employee and you or a covered dependent enroll in Medicare Part D prescription drug coverage, the Prescription Drug Program will continue to be the primary coverage for the person(s) enrolled in Medicare Part D (i.e., will pay first). If you or a covered dependent are covered under the Prescription Drug Program and Medicaid or other similar state programs for prescription drugs, in most instances your prescription drug coverage is your primary drug coverage. You should purchase your prescription drugs using your Express Scripts ID card and submit out-of-pocket co-pay expenses to Medicaid or other similar state programs. Because the Prescription Drug Program does not have a coordination of benefits provision, you may not submit claims to Express Scripts for reimbursement after any other payor has paid primary or has made the initial payment for the covered drugs.

Converting Coverage to an Individual Policy

There is no separate conversion policy available under the prescription drug plan.

Administrative Information

Information about many subjects relating to the administration of this plan and your Crown Castle medical coverage may be found in the SPD and in the other governing plan documents. Subjects discussed in the SPD include the right of the company and the claims administrator to interpret the plan; your rights under the federal law known as ERISA; the company’s right to amend or terminate this plan; assignment of benefits; facility of payment; subrogation; claims or creditors; recovery of excess payments; payment adjustments; release of information; and other important administrative information about this plan. Certain important legal notices are also included in your SPD.