CROWN CASTLE INC.
EMPLOYEE ASSISTANCE PROGRAM

SUMMARY PLAN DESCRIPTION

Effective January 1, 2023

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INTRODUCTION

This booklet describes the Employee Assistance Program ("EAP") maintained by Crown Castle Inc. (the "Company") as part of the benefits payable under the Crown Castle Inc. Health and Welfare Plan (the "Plan"). This booklet is a Summary Plan Description for the EAP benefit, and is also a component of the Crown Castle Inc. Health and Welfare Plan. The EAP is administered by Lyra Health, Inc.. The EAP is a benefit that connects employees and their dependents to mental and emotional health care that is effective, convenient, and personalized. The EAP also provides work-life services to help you work through personal life obstacles. These services include legal, identity theft, financial, and dependent care services.

The continued maintenance of the EAP is completely voluntary on the part of the Company and neither its existence nor its continuation will be construed as creating any contractual right to or obligation for its future continuation. The Company reserves the right at any time and for any reason, in its sole and absolute discretion, to curtail benefits under, or otherwise amend, modify, or terminate the EAP or any portion thereof, including, without limitation, those portions of the EAP outlining the benefits provided or the classes of employees or dependents eligible for benefits under the EAP. If the EAP is terminated, the rights of the Plan participants are limited to expenses incurred before termination.

ELIGIBILITY

The EAP benefit is available to all employees of the Company, their spouses, their domestic partners and their dependents (up to age 26). You are eligible to enroll in the Plan if you are a regular full-time, part-time, hourly or salaried employee who is regularly scheduled to work at least 20 hours per week.

Your eligible dependents may also participate in the Plan:

- Your legal spouse
- Your domestic partner
- Dependent children – yours, your spouse's or your domestic partner's
    - Dependent children must be under 26 years of age
    - Dependent children include:
        - Natural children
        - Stepchildren
        - Adopted children including those placed with you for adoption

- A child for whom you, your spouse or your domestic partner are the legal guardian
- Children you are responsible for under a qualified medical support order or court order
- An unmarried child age 26 or over who is or becomes disabled and dependent on you

COVERAGE AND LIMITATIONS

SERVICES COVERED

The EAP can help with stress, anxiety, depression, communication issues, and other common issues that can be addressed through short-term care services such as therapy, coaching, or self-guided apps.

The EAP covers up to 16 sessions (including therapy and mental health coaching) per calendar year. Participants are eligible for one free consultation for each type of work life consultation service provided, after which you will be able to pay a discounted fee if you choose to continue engagement with the service.

SERVICES EXCLUDED

Services that are not covered include: long-term psychiatry, inpatient or residential treatment, hospitalization (including partial), intensive outpatient treatment, emergent care, long-term care or counseling, prescription medication, autism spectrum disorder treatment, services for remedial education, executive coaching, and non-evidence-based behavioral health care. Please refer to your medical plan booklet for information on coverage of these excluded services.

DESCRIPTION OF BENEFITS

The EAP covers short-term, evidence-based outpatient mental health services, at no cost to you. There are no copays, no deductibles, and no prior authorizations or referrals needed to begin care. The Company medical plan provides benefits for many other conditions, such as certain types of intensive care such as medication management, emergency care, long-term care, or psychiatric conditions that would require hospitalization.

MENTAL HEALTH COACHING

Mental health coaches can help you pin-point what you're dealing with and can support a range of challenges including stress, anxiety, burnout, grief, relationship challenges, loneliness, perfectionism, life transitions, mild depression and more.

Meeting with a coach can help get to the root of a problem, gain new insights, and see things through a new lens. Sessions can be weekly, bi-weekly, or even monthly. Between sessions you'll get activities and strategies to build on what you learn, and you can message your coach if anything comes up.

SELF-GUIDED CARE

You can start with a consultation session with a coach. Afterwards, the coach will craft a personalized care plan with exercises and strategies for you to work on independently. A coach can help keep you on track, provide specific feedback, and be available via messaging for questions and support.

SHORT-TERM THERAPY

Short-term Therapy is a method of caring for your mental and emotional health — your sense of well-being which enables you to meet the demands of everyday life. The EAP only supports evidence-based therapies, which means that the methods used by our providers and self-guided therapy programs have been proven to work.

WORK-LIFE SERVICES

The EAP offers Legal, Financial, Identity Theft, and Dependent Care services to assist you and your family during challenging times.

- Legal services include a free 30-minute consultation with an attorney or mediator and access to 24-hour emergency support.
- Financial services include a free 30-minute consultation with a financial counselor and a free 30-minute consultation with a CPA.
- Identity Theft services include a free 60-minute consultation with a fraud resolution specialist and a free ID emergency response kit.
- Dependent Care services include resources and referrals for child, elder, and pet care and 24-hour online and phone support.

For more information on these benefits, please visit the work-life service page or contact the Lyra team at (844) 903–3658.

HOW THE EAP WORKS

ASSESSMENT

Assessments can be done online or by calling Lyra at (844) 903-3658. You can also get information on care options, such as a therapist, coach, or self-guided program.

CARE FORMATS

Short-term Therapy can be done in a provider's office or by live video from any place with an internet connection. Mental health coaching can be done by live video or by telephone. There are also digital self-guided apps available. Not sure what is right for you? The Lyra care team can answer your questions 24/7 by phone at (844) 903–3658, by email at care@lyrahealth.com, or by web chat at crowncastle.lyrahealth.com.

LIVE MESSAGING

Live messaging sessions are available to members in Mental Health Coaching. Sessions take place on Lyra's HIPAA-compliant and secure platform and last up to 45 minutes so you have plenty of time to connect with your Lyra coach. During your session, your coach will message with you and be 100% focused on your conversation. If you start with live messaging coaching sessions, you'll always have the flexibility to switch between live messaging and video sessions for added convenience.

LIVE VIDEO

To protect your privacy, Lyra requires providers to utilize HIPAA-compliant and secure platforms. Your provider will share additional information and instructions about which platform they use and how to meet via live video.

CANCELLATIONS

When you start care, it's important to talk to your provider about their cancellation policy. Most providers require 24-48 hour notice for cancellations. Please refer to your provider for questions about their cancellation policy and fees. If you do not cancel on time or miss an appointment without cancelling, for any reason, you will be required to reimburse your provider for the missed session. Any missed or late sessions will count against the 16 sessions you get per calendar year.

CONTINUING SERVICES

If you reach your 16-session limit for the year, you may elect to continue working with your Lyra provider, but any future sessions would require out-of-pocket payment. Alternatively, you may opt to find a provider who is in-network with your medical plan.

CLAIMS PROCEDURES

CLAIMS ADMINISTRATOR

The Plan Administrator is the Claims Administrator for eligibility claims. Lyra Health, Inc. is the Claims Administrator for EAP benefit claims. Find the contact information for the Plan Administrator and the claims and appeals procedures for benefit claims at the end of this Summary Plan Description and in the Health and Welfare Plan SPD.

ELIGIBILITY CLAIMS

You have 90 days from the date on which the relevant event occurred to make a claim for eligibility under the EAP. You must exhaust the EAP's appeal procedures before you can bring an action in law or equity to recover benefits under the benefit program. If your appeal is denied in whole or in part, you have the right to bring a civil action pursuant to ERISA Section 502(a) within 90 days of receiving a final determination, notwithstanding any other statute of limitations.

ELIGIBILITY CLAIM APPEALS

If you (or your duly authorized representative) disagree with the decision in the initial denial, you can file an appeal with and request a full review by the Plan Administrator. If you do not agree with the Plan Administrator's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within one-hundred eighty (180) days of receipt of the initial denial notice.

As part of the review procedure, you or your representative are entitled to:

- Examine and obtain copies, free of charge, of all EAP plan documents, records and other information that were used in making the determination.

- Submit written comments, documents, records, and other information relating to the claim or request;

- Obtain information identifying the medical or vocational experts whose advice was obtained on behalf of the Plan Administrator in connection with the denial of the claim or request. (You are entitled to this information even if the Plan Administrator did not rely on the information in making its determination.)

- Have someone act as your representative in the review procedure, if you wish.

The decision on appeal will be made within sixty (60) days after receiving your appeal, unless special circumstances require an extension of an additional sixty (60) days. If the period is extended, the Plan Administrator will notify you in writing of the extension within sixty (60) days of receiving your appeal. The notice of denial on appeal will contain the same type of information outlined in subsection (A) above, including your right to bring a civil action following a denial of your appeal. The Plan Administrator's decision on appeal review will be final and binding on you, your eligible dependent(s) and any other interested party.

COMPLIANCE WITH FEDERAL LAWS

The terms of the EAP will be construed and administered in a manner calculated to meet the requirements of the following laws, and any amendments thereof, as they are applicable to the EAP:

Americans with Disabilities Act of 1990,

Health Insurance Portability and Accountability Act of 1996,

Personal Responsibility and Work Opportunity Reconciliation Act of 1996,

The Newborns' and Mothers' Health Protection Act of 1996,

Mental Health Parity Act of 1996,

Women's Health and Cancer Rights Act of 1998,

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,

Genetic Information Nondiscrimination Act of 2008,

Children's Health Insurance Program Reauthorization Act of 2009,

American Recovery and Reinvestment Act of 2009,

Patient Protection and Affordable Care Act of 2010,

Health Care and Education Reconciliation Act of 2010, and

Any other federal law or applicable guidance that may apply to the Plan.

To the extent a provision is contrary to or fails to address the minimum requirements of these laws, the Plan will provide the coverage or benefit necessary to comply with the minimum requirements thereof.

GENERAL PLAN INFORMATION

FUNDING

The EAP is self-insured, meaning that benefits are paid by the Company and affiliated entities. The costs of this Plan are paid by the Company.

EFFECTIVE DATE

The Summary Plan Description is a summary of EAP provisions in effect as of January 1, 2023.

EAP ADMINISTRATOR

Lyra
(844) 903-3658
crowncastle.lyrahealth.com

APPENDIX A: BENEFIT CLAIM AND APPEAL PROCEDURES

Claims

A "Claim" is a written request for a benefit under this Plan. Most benefits will be provided and paid without the need for you to file a Claim. However, if you believe that you were not provided benefits to which you are entitled under the Plan, you must file a Claim to get those benefits.

To submit a Claim, you may complete an online form available at www.lyrahealth.com/feedback or send your Claim in writing to feedback@lyrahealth.com with the following information: your name, phone number, date of birth, employer through whom you receive this benefit, a description of benefit you are requesting under the Plan, and any relevant facts or documents to your request. You may also submit your claim by U.S. mail to Lyra Health, Inc., 287 Lorton Avenue, Burlingame, CA 94010. Your claim must be received no later than one year after the date on which the applicable event occurred. If you fail to follow these procedures, the Claim will be treated as if it had not been filed.

If your Claim is approved, Lyra will provide written or electronic notice of such approval. If your Claim is denied (in whole or in part), Lyra will provide you with written or electronic notice of such denial. The notice of Claim denial will include:

- The specific reason that the Claim was denied;
- A reference to the specific provisions of the Plan on which the denial was based;
- A description of any additional material or information necessary to perfect the Claim and an explanation of why this material or information is necessary;
- A description of the appeal procedures and the time limits that apply to such procedures, including a statement of your right to bring a civil action within 90 days under ERISA § 502(a) if the Claim is denied on appeal;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the Claim, either (A) the specific rule, guideline, protocol, or other similar criterion, or (B) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the decision and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- If the denial is due to the fact that the services requested were not clinically indicated, either (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request.

Lyra will render a Claim decision no more than 30 days after its receipt of the Claim, unless Lyra requires a 15-day extension of time to review the Claim. If Lyra requires an extension, it will provide you with written or electronic notice of the extension before the initial 30-day period ends. The notice of the extension will include:

- An explanation of the circumstances requiring the extension, which circumstances must be matters beyond the control of Lyra;
- The date by which Lyra expects to render a decision;

- The standard on which your entitlement to a benefit is based; and
- The unresolved issues (if any) that prevent a decision on the Claim, and the information needed to resolve those issues. In the event such information is needed, you will have at least 45 days in which to provide the specified information. In addition, Lyra's time for deciding the Claim will be tolled from the date on which the notice of extension is sent to you until the date on which you respond to the request for additional information.

IF YOU DO NOT AGREE WITH THE DENIAL, YOU SHOULD APPEAL WITHIN 180 DAYS. IF YOU FAIL TO DO SO, THE DENIAL BECOMES FINAL AND CANNOT BE APPEALED. THE APPEAL PROCEDURES ARE BELOW.

Appeals

If a Claim is denied (in whole or in part), you may appeal the denial by providing a written notice of appeal within 180 days after you receive the notice of Claim denial. The notice of appeal should be sent to: feedback@lyrahealth.com, along with the details of your appeal. When you submit a notice of Appeal, you may also submit written comments, documents, records, and other information relating to the Claim. Upon request, you are entitled to review and receive, free of charge, copies of all documents, records, and other information relevant to the initial Claim (whether a document is relevant will be determined pursuant to 29 C.F.R. § 2560.503-1(m)(8)).

In deciding the Appeal:

- No deference will be given to the decision denying the initial Claim.
- The Appeal will be decided by an individual who did not decide the initial Claim and who is not a subordinate of anyone who decided the initial Claim.
- The individual deciding the Appeal will review and consider all information you submitted, without regard to whether the information was submitted or considered in conjunction with the initial Claim.
- If the Appeal is based, in whole or in part, on a clinical judgment, the individual deciding the Appeal will consult with a health care professional who has appropriate training and experience in the relevant field—the health care professional will not be an individual who participated in the denial of the initial Claim and will not be the subordinate of any such individual.
- If Lyra obtained advice from any clinical experts in conjunction with the initial Claim, the experts will be identified to you, whether or not Lyra relied on the advice obtained.
- If Lyra obtains new or additional evidence that it intends to consider or rely upon in deciding the Appeal, Lyra will provide the new information or evidence to you as soon as possible and will give you a reasonable opportunity to respond.

If your Appeal is approved, Lyra will provide written or electronic notice of such approval. If your Appeal is denied (in whole or in part), Lyra will provide you with written or electronic notice of such denial. The notice of Appeal denial will include:

- The specific reason or reasons for the Appeal decision;
- Reference to the specific provisions of the Plan on which the Appeal decision 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 the Claim and Appeal (whether a document, record, or other information is relevant to a Claim or Appeal will be determined by reference to 29 C.F.R. § 2560.503-1(m)(8));
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the Appeal, either (A) the specific rule, guideline, protocol, or other similar criterion, or (B) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request;
- If the denial is due to the fact that the services requested were not clinically indicated, either (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request; and
- A statement of your right to bring an action under ERISA § 502(a) within 90 days of receiving a final adverse benefit determination, notwithstanding any other statutes of limitation.

Lyra will render an Appeal decision no more than 60 days after its receipt of the notice of Appeal.

Legal Action

You generally must exhaust your administrative remedies under these procedures prior to bringing any legal action with respect to a Claim or Appeal.