CHESAPEAKE UTILITIES CORPORATION

A Guide to Your Benefits

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please refer to the Medicare D notice in this benefits guide for more details.

2022

Open Enrollment 2022

Chesapeake Team Members,

I am pleased to share with you our 2022 Employee Benefits Guide. This Guide is prepared especially for you to help you make informed decisions on this year's open enrollment/new hire enrollment. Open enrollment for the 2022 Benefit Year begins on November 1, 2021 and ends on November 19, 2021.

Each year, we review the overall healthcare trends in the marketplace and carefully design our medical plans to remain competitive compared to the industry and our peer companies. Healthcare costs continue to rise and we have designed our plans to accommodate our employees' wide range of needs.

For 2022, the medical, dental and vision plans will have no adjustments to copays, deductibles and coinsurance amounts. The Short-Term Disability (STD) plan will become voluntary and employees will need to purchase that benefit in order for it to continue.

Company contributions for HSA are increased to $750 for employee; $1,500 for employee plus one and $2,250 for employee and family. During the open enrollment meetings, the Human Resources team will review all of the updates to our Company benefits.

Additionally, please know that all of Chesapeake Utilities Corporation's medical options are fully compliant with the Affordable Care Act and offer benefits that are well in excess of all minimum requirements required under the law. We are very happy to report that the breadth of the Highmark Blue Cross and Blue Shield physician network and the strength and affordability of our Company plans represent excellent options for our employees when compared with plan and cost options available in the marketplace.

Here are a few tips to help you make informed choices:

Become actively engaged in your open enrollment to make informed choices that best suit your needs. Assess your needs, analyze how you used your plan benefits in 2021 and consider adjustments that are most appropriate for your stage of life and that of your family. This will provide you with a view of how you are spending your benefit dollars.

Make sure you understand all of the benefits that are offered and how you and your family may use them. This will avoid confusion around different plan offerings. If you are unsure, meet with your HR Business Partner identified on page 20 of this Guide.

You will continue to see increased communications regarding benefits and wellness efforts, and we welcome your feedback and ideas. In 2022, we are adding a new *Chesapeake Well-Being Program* through our partnership with Propel. This program will provide health assessments, walking/activity challenges and biometric screenings as well as resources and lifestyle coaching in areas of wellness, fitness and nutrition.

Our comprehensive benefit programs are designed to help you achieve your health and wellness goals over the coming calendar year and beyond. We genuinely care about your health and well-being and hope you use this important open enrollment period to put wellness to work for you and your family.

Continued Good Health and Well-Being,

William Hughston
Vice President & Chief Human Resources Officer

YOUR CHESAPEAKE UTILITIES CORPORATION BENEFITS

Employee benefits are significant in the lives of you and your family. To ensure that you and your family have the optimal coverage, you have the opportunity to elect, apply for or make changes to your benefits package as a new hire and annually during open enrollment. Benefits are effective for the calendar year, beginning January 1 through December 31.

This benefits guide can help familiarize you with the Company's benefit options. The guide provides useful tips, tools and resources. **As you review your benefits options and prepare to enroll:**

- Consider your benefit coverage needs for the upcoming year. For example, is your family financially protected if you can't work due to an accident or illness?
- Consider other available coverage.
- Gather information you'll need. If you are covering dependents, you will need their dates of birth and Social Security numbers. In addition, you may need to provide legal documentation verifying their eligibility — such as a marriage license or birth certificate.

Getting the most value from your benefits depends on how well you understand your plans and how you choose to use them. Be sure to read this entire guide for important information about your benefit options.

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Enrolling in Your Benefits

Log in at https://e12.ultipro.com/Login

Begin the benefits enrollment process

Elect the benefits you want

Save or submit your elections

Print a copy of your elections for your records

BENEFIT BASICS

Chesapeake Utilities Corporation provides benefits coverage that includes benefits costs shared by the Company and the employee, the Company only or the employee only, as follows:

Benefit	Contribution	Who Pays
Medical and Pharmacy	Pretax	Company & You
Dental	Pretax	Company & You
Voluntary Vision	Pretax	You
Health Savings Account	Pretax	Company & You
Flexible Spending Accounts	Pretax	You
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	N/A	Company
Voluntary Life and AD&D Insurance	Post-tax	You
Voluntary Short-Term Disability	Post-tax	You
Long-Term Disability*	N/A	Company
401(k) Retirement Savings Plan	Pretax	Company & You

***Taxability for Long-Term Disability (LTD) Benefits:**

Option 1 - Electing to not pay tax on the amount of the LTD premium paid on your behalf by the Company. In the event of an approved LTD claim, the benefit paid by the insurance company will be considered taxable.

Option 2 - Electing to pay tax on the amount of the LTD premium paid on your behalf by the Company. In the event of an approved LTD claim, the benefit paid by the insurance company will not be subject to Federal or FICA tax.

ELIGIBILITY

Employees who work at least 30 hours per week are eligible for the benefits described in this guide.

New employees to the Chesapeake Utilities Corporation family are eligible to receive health care benefits on the first day of the month following their date of hire for medical, dental, vision, life insurance and FSA, if actively employed. If actively employed, **Contact Human Resources to ensure new hire enrollment requirements are completed in a timely manner.**

Dependent Eligibility – Medical, Dental, Vision and Voluntary Term Life Insurance

Dependent eligibility for medical, dental, vision and voluntary term life defines a dependent as the employee's legal spouse, or dependent child. Dependent children will be covered through the end of the month in which they turn age 26. A dependent child is defined as:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child for whom legal guardianship has been awarded to the covered employee or the employee's spouse.
- Unmarried children currently enrolled in a Company plan of any age who become mentally or physically disabled before reaching the age limit of 26.

Changes to your benefits

Employees may make changes to their benefits when there is a qualifying change in status. There are certain circumstances where changes to elections made during open enrollment may be modified. These qualifying events are guided by the IRS Section 125 Rules.

- Marriage
- Divorce or legal separation
- Death
- Birth, adoption or legal custody of a dependent child
- Involuntary loss of other group insurance coverage
- Spouse's open enrollment

You have 30 days from the qualified life event to make changes to your coverage. Depending on the type of event, you may need to provide proof of the event, such as a marriage license. If you do not make the changes within 30 days of the qualified event, you will have to wait until the next open enrollment period to make changes (unless you experience another qualified life event).

It is important that you contact Human Resources within 30 days of a qualified life event or within 60 days if the event is due to a loss of CHIP coverage. If you and/or your dependents have Medicare or will become eligible for Medicare within the next 12 months, a Federal law gives you choices about your prescription drug coverage. Please see page 26 for information.

Enrollment Checklist

- Verify home address, marital status and emergency contact information - ID plan cards and addresses are generated from the information entered into UKG. Incorrect information will cause delays. If you make any changes to your marital status, you must submit proof of marriage or divorce to Human Resources for the requested change to be completed.
- Confirm your eligible dependents. Verify each dependent's name, date of birth, and Social Security number. If adding a new dependent, a copy of the dependent's birth certificate must be provided.
- Confirm dependent children are eligible for and do not exceed the age limit of 26 for medical, dental, and vision plans.

For additional information and assistance, please contact Human Resources.

MEDICAL AND PHARMACY PLAN OVERVIEW

We offer the choice of four medical plans through Highmark BlueCross BlueShield Delaware (Highmark BCBSDE). All four plans are open access and you do not need a referral to seek care from a specialist. You may seek care from any provider you choose; however, if the provider is out of the network, there is no agreement in place to allow for discounted pricing, and you may be billed for the balance. All of the medical options include coverage for prescription drugs. To select the plan that best suits your family, you should consider the key differences between the plans, the cost of coverage (including payroll deductions), and how the plan covers services throughout the year.

Understanding how your plan works

1. YOUR DEDUCTIBLE

You pay out-of-pocket for most medical and pharmacy expenses, except those with a copay, until you reach the deductible.

You can pay for these expenses from your Health Savings Account (HSA), if you are covered by the HDHP plan.

2. YOUR COVERAGE

Once your deductible is met, you and the plan share the cost of covered medical and pharmacy expenses. The plan will pay a percentage of each eligible expense and you will pay the remainder of the expense.

3. YOUR OUT-OF-POCKET MAXIMUM

When you reach your out-of-pocket maximum, the plan pays 100% of covered medical and pharmacy expenses for the rest of the plan year. Your deductible and coinsurance apply toward the out-of-pocket maximum.

Making the most of your plan

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

- **In-network providers and pharmacies:** You will always pay less if you see a provider within the medical and pharmacy network.
- **Preventive care:** In-network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms.
- **Preventive drugs:** Many preventive drugs and those used to treat chronic conditions like diabetes, high blood pressure, high cholesterol and asthma. These prescriptions are covered at 100% (no cost to you) when you use an in-network pharmacy.
- **Mail Order Pharmacy:** If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can use the Mail Order Pharmacy to save on a 90-day supply.
- **Pharmacy coverage:** Medications are classified based on drug cost, safety and effectiveness.
  - **Generic** – A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.
  - **Brand preferred** – A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.
  - **Brand non-preferred** – A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs.
  - **Specialty** – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

MEDICAL AND PHARMACY COVERAGE

Medical Plan Provisions	OPTION 1: EPO – Low	OPTION 2: EPO – High	OPTION 3: PPO		OPTION 4: EPO – HDHP HSA
	In-Network	In-Network	In-Network	Out-of-Network	In-Network
Company contribution to HSA (Employee/Employee + 1/Family)	N/A	N/A	N/A	N/A	$750/$1,500/ $2,250
Annual Deductible (Individual/Family)	$1,000/$2,500	$750/$1,500	$500/$1,000	$2,000/$4,000	$2,000/$4,000
Out-of-Pocket Maximum (Includes Deductible)	$4,000/$8,000	$2,500/$5,000	$2,000/$4,000	$5,000/$10,000	$4,000/$8,000
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%	30%*	Covered at 100%
Primary Care Provider Office Visit	$30 copay	$20 copay	$20 copay	30%*	20%*
Specialist Office Visit	$60 copay	$40 copay	$40 copay	30%*	20%*
X-Ray and Lab	$25/$60	Covered at 100%	Covered at 100%	30%*	20%*
MRI, MRA, CT & PET Scans	25%*	15%*	10%*	30%*	20%*
Inpatient Hospital Services	25%*	15%*	10%*	30%*	20%*
Outpatient Hospital Services	25%*	15%*	10%*	30%*	20%*
Urgent Care	$75 copay	$75 copay	$75 copay	30%*	20%*
Emergency Room	$50 copay, 25%*	$50 copay, 15%*	$50 copay, 10%*	30%*	20%*
Retail Pharmacy (up to a 30-day supply)					
Generic	$10 copay	$10 copay	$10 copay	$10 copay	20%*
Brand Preferred	$45 copay	$45 copay	$45 copay	$45 copay	20%*
Brand Non-Preferred	$70 copay	$70 copay	$70 copay	$70 copay	20%*
Mail Order Pharmacy (90-day supply)					
Generic	$20 copay	$20 copay	$20 copay	$20 copay	20%*
Brand Preferred	$90 copay	$90 copay	$90 copay	$90 copay	20%*
Brand Non-Preferred	$140 copay	$140 copay	$140 copay	$140 copay	20%*

*After deductible

The HDHP plan includes an Enhanced Preventive Drug List that waives the deductible and coinsurance for certain chronic condition medications, effective January 1, 2022.

Your payroll contributions for medical benefits are shown here.

Coverage Level	OPTION 1: EPO – Low	OPTION 2: EPO – High	OPTION 3: PPO	OPTION 4: EPO – HDHP HSA
	Bi-Weekly	Bi-Weekly	Bi-Weekly	Bi-Weekly
Employee Only	$74	$101	$152	$49
Employee + 1	$141	$192	$288	$93
Family	$216	$293	$436	$137

MEDICAL PLAN RESOURCES

Find a Highmark Blue Cross Participating Provider

1. Go to www.highmarkbcbsde.com
2. Click on "Find A Doctor OR Pharmacy" at the top of the home page
3. Select "Find a Doctor, Hospital or other Medical Provider" on the following page
4. Under "Plan name," enter "BCBS EPO" if you are enrolled in one of the two EPO plans, HDHP or enter "BCBS PPO" if you are enrolled in the PPO plan
5. Type a name, hospital, clinic, specialty or condition
6. Enter a location and distance
7. Click on "Search" to display your search criteria

Virtual Medicine

Highmark BCBSDE provides members with 24/7 access to virtual medicine. This program includes U.S. licensed, board-certified doctors who can diagnose and treat most non-emergency illnesses. They can also prescribe medications when appropriate. Virtual doctors can treat sinus infections, upper respiratory infection, bronchitis, flu, conjunctivitis, cough and sore throat. **Visit www.amwell.com and follow the instructions to register and download the mobile apps. You can use either or both of these services, depending on the availability of virtual doctors in your area.**

Copays for Virtual Medicine are:

- EPO High - $15 copay
- EPO Low - $30 copay
- PPO Plan - $15 copay
- HDHP Plan - $59 allowance (applied to deductible)

Davis Vision Discount Program offered through Highmark

Highmark members have access to a program that offers discounts on exams, contacts, lenses and frames.

Please see the flyer for a complete schedule of benefits. To find a provider, go to www.highmarkbcbsde.com and click on "Find a Doctor or Pharmacy." Click on "Find an Eye Care Provider." Enter zip code and mile radius and then click "Search Now" to see the most current listing of providers that will accept your discount plan. Or call 800-999-5431 for more information.

This plan is separate from EyeMed and cannot be used in conjunction with the standalone EyeMed vision plan.

Prescription Coverage

All four medical plans include prescription coverage. Highmark's prescription formulary includes approved generic and brand-name drugs. The placement of a specific drug may periodically change due to changes in patents, new drugs becoming available in a generic form or newly approved FDA drugs.

To review the Highmark prescription formulary, visit www.highmarkbcbsde.com:

1. Click on "Find a Doctor or Pharmacy" (top of home page)
2. Click on "Find a Drug"
3. Select "Comprehensive Formulary"
4. Enter the name of the medication under Brand and Generic name search or search for a medication under Therapeutic Class search

The mail order process:

- **Online:** Register at www.highmarkbcbsde.com.
- **By mail:** Contact Human Resources for a Highmark BCBSDE mail order registration form. Mail the form along with your original prescription.
- **By phone:** Call Express Scripts Member Services. Your insurance information is required.
- To start your mail order service, request two prescriptions from your care provider – one for an initial short-term supply that your local pharmacy can fill immediately and one for a 90-day supply with three refills to mail to Express Scripts.
- **Mail prescriptions to:** Express Scripts Home Delivery Service, P.O. Box 6500, Cincinnati, OH 45273
- **Express Scripts Member Services:** 800-903-6228. Available 24 hours, 7 days a week (except on Thanksgiving and Christmas).

SAVINGS ACCOUNTS

The Company offers several accounts that enable you to pay for eligible expenses tax-free. The IRS provides a list of eligible expenses for each account at www.irs.gov.

Health Savings Account (HSA)

Available to those enrolled in the HDHP.

An HSA provides a triple tax advantage: funds are deposited on a pre-tax basis through payroll contribution or Company funding; the money is not taxed if you use it for qualified expenses and the account grows, tax-free.

Health Care Flexible Spending Accounts (FSAs)

Your options depend on your medical plan enrollment.

- **Health Care FSA** – If you are not enrolled in an HDHP Plan, you can use this account for medical, pharmacy, dental and vision expenses.
- **Limited Purpose FSA** – If you are enrolled in an HDHP Plan, you can use this account to pay for dental and vision expenses only.

Dependent Care Flexible Spending Account (FSA)

Use for eligible childcare expenses for dependents under age 13 or eldercare.

Comparison of accounts

	HSA	FSA
Does the Company contribute? *Amount for full-year 2022*	✓ Employee: $750 Employee + 1: $1,500 Family: $2,250	✗
Can I contribute my own savings?	✓	✓
Is there an IRS maximum annual contribution?	✓ Employee: $3,650 Family: $7,300 Those 55 and older can contribute an additional $1,000 annually.	✓ Health Care or Limited Purpose FSAs: $2,750 Dependent Care FSA: $5,000
Will my savings roll over each year?	✓ Unlimited	! Up to $550 for Health Care and Limited Purpose FSAs; No roll over for Dependent Care FSA
Will I earn interest on my savings?	✓	✗
Are the savings tax-free? *In most states*	✓	✓
Do I keep the money if I leave the Company?	✓	✗
Can I also have a Flexible Spending Account (FSA)?	! Limited Purpose and Dependent Care FSAs only	N/A

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a savings account that belongs to you that is paired with the HDHP. It allows you to make tax-free contributions to a savings account to pay for current and future medical expenses for you and your dependents.

START IT

- Contributions to the HSA are tax-free whether contributions are made by you or the Company. The Company contributes $750 for individual coverage, $1,500 for individual + 1 coverage, and $2,250 for family coverage.
- Medical plans paired with an HSA are typically less, per pay, than other plans. The money you save on payroll contributions can be used to fund the HSA. You save money on taxes and have more flexibility and control over your health care dollars.

BUILD IT

- All of the money in your HSA is yours (including any contributions deposited by the Company) even if you leave your job, change plans or retire.
- In 2022, the total of your contributions and the Company's can be up to $3,650 for individual coverage and $7,300 for family coverage.
- You can move funds from an IRA to an HSA (only if you're eligible to make contributions to your HSA). You can only roll funds from an IRA to an HSA once per lifetime. The maximum amount you can roll over is the same as your annual maximum contribution limit for that year.

USE IT

- You can withdraw your money tax-free at any time, as long as you use it for qualified expenses (a list can be found on www.irs.gov).
- You can also save this money and hold onto it for future eligible health care expenses as funds roll over from year to year.
- You will be issued a debit card to use for approved qualified expenses.
- You can use your HSA for qualified expenses incurred after the account is established. You cannot use funds for services incurred prior to the effective date of the HSA.

GROW IT

- Unused money in your HSA will roll over, earn interest and grow tax-free over time.
- You decide how to use the HSA money, including whether to save it or use it for qualified medical expenses. When your balance is large enough, you can invest it — tax-free.

Eligibility Details

- If you are age 55 or older, you can contribute an additional $1,000 per year.
- Per IRS regulations, you may not contribute to an HSA unless you are covered by a qualified HDHP. The Company's HDHP meets the requirement.
- According to IRS guidelines, you may not open or contribute to an HSA if you are covered by any other health plan (unless it's another qualified HDHP), if you are on Medicare or claimed as a dependent on someone else's tax return.
- You cannot participate in a standard Health Care Flexible Spending Account (FSA), if either you or your spouse have an HSA. Your spouse also cannot have a Health Care FSA.

Health Insurance premiums are not qualified medical expenses. However, there are a few exceptions. HSA funds can be used for qualified long-term care insurance, COBRA premiums, health care coverage while on unemployment, Medicare premiums for Part A, B & D, and Medicare HMO.

Refer to IRS Publication 502 for more information regarding eligible expenses.

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) helps you pay for health care or dependent care costs using tax-free dollars. Your contribution is deducted from your paycheck on a pretax basis and is put into the FSA. When you incur expenses, you can access the funds in your account to pay for eligible expenses. The following chart shows the eligible expenses for each FSA and how much you can contribute each year. Each of these options reduces your taxable income.

Account type	Eligible expenses	Annual contribution limits
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan (such as copays, coinsurance, deductibles, eyeglasses and prescriptions)	Maximum contribution is $2,750 per year. You cannot enroll if you are enrolled in the HDHP with an HSA. Funds are deducted throughout the year, but all funds are available on January 1.
Limited Purpose FSA **This is available to those enrolled in the HDHP with an HSA.**	Dental and vision expenses only that are not covered by your health plan (such as copays, coinsurance, deductibles, eyeglasses and prescriptions)	Maximum contribution is $2,750 per year. Funds are deducted throughout the year, but all funds are available on January 1.
Dependent Care FSA	Dependent care expenses (such as daycare, after school programs or eldercare programs) for children under age 13 or eldercare so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns).

Important information about FSAs

Your FSA elections are effective from January 1 through December 31. Claims for reimbursement must be submitted by March 31 of the following year. Our Health Care or Limited Purpose FSAs allow you to carry over $550 in unused funds to the following plan year.

Please plan your contributions carefully. Any unused money remaining in your account(s) will be forfeited. This is known as the “use it or lose it” rule and it is governed by Internal Revenue Service regulations. Note that FSA elections do not automatically continue from year to year. You must actively enroll each year.

Debit Card

Your FSA debit card will work at most health care related merchants including doctors, dentists, pharmacies and grocery stores. There may be times when you will have to produce a receipt for a debit card transaction, according to IRS rules. You can find more information regarding these rules at www.ebcflex.com/iiasresources. It is recommended that you retain your debit card receipts. If you choose not to use your debit card, you can file a paper claim by mail, fax or email by sending the receipt and completed claim form to EBC. You can also use your Android or Apple phones to send a claim or attach documentation.

For more information regarding the BESTflex Plan with the Benefits Card: https://www.ebcflex.com/fsabenefitscard/

Manage your FSA online by using My Account Assistant. Login to www.ebcflex.com and click participant login to get started. You can also access your account via mobile phone at My Mobile Account Assistant, or go to www.ebcflex.com/ebcmobile.

DENTAL PLAN

It's important to have regular dental exams and cleanings so problems are detected before they become painful — and expensive. Keeping your teeth and gums clean and healthy will help to prevent most tooth decay and is an important part of maintaining your overall health. We offer two dental plan options through Delta Dental.

Plan Provisions	Delta Dental PPO Plan		Delta Dental PPO Buy-Up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$50/$150		$50/$150	
Calendar Year Maximum	$1,500 per individual		$2,500 per individual	
Orthodontia Lifetime Maximum	$1,500 per individual		$1,500 per individual	
Diagnostic and Preventive Services (e.g., X-rays, cleanings - 3 x per calendar year, exams - 2 x per calendar year)	Covered at 100%		Covered at 100%	
Basic and Restorative Services (e.g., fillings)	20%*		20%*	
Major Services (e.g., dentures, crowns, bridges)	50%*		50%*	
Orthodontia	50% for adult & child(ren)		50% for adult & child(ren)	

*After deductible

Your payroll contributions for dental benefits are shown here.

Coverage Level	Delta Dental PPO Plan	Delta Dental PPO Buy-Up Plan
	Bi-Weekly	Bi-Weekly
Employee Only	$12.84	$13.80
Employee + 1	$25.68	$27.60
Family	$38.53	$41.42

Using in-network dental providers

While you have the option of choosing any provider, you will save money when you use in-network dentists. When using an out-of-network dental provider, you will pay more because the provider has not agreed to charge you a negotiated rate.

VISION PLAN

The vision plan provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can choose any provider; however, you always save money if you see in-network providers. We offer a voluntary vision plan through EyeMed.

Plan Provisions	EyeMed Insight Vision Network	
	In-Network	Out-of-Network
Exam	$10 copay	Up to $40
Frames	$130 allowance plus 20% off balance over $130	Up to $91
Lenses		
• Single Vision Lenses	$25 copay	Up to $30
• Bifocal Lenses	$25 copay	Up to $50
• Trifocal Lenses	$25 copay	Up to $70
• Leticular Lenses	$25 copay	Up to $70
• Progressive - Standard	$90 copay	Up to $50
• Progressive - Premier Tier 1-3	$110-$135 copay	Up to $50
• Progressive - Premier Tier 4	$90 copay; 20% retail price less $120 allowance	Up to $50
Contact Lenses		
• Exam & Fitting Standard/Premium	Up to $55 Allowed/10% off Retail	N/A
• Conventional	$130 Allowance then 15% discount	Up to $130
• Disposable	$130 Allowance Only	Up to $130
• Medically Necessary	Covered at 100%	Up to $210
Frequency		
• Exam	Every 12 months	Every 12 months
• Lenses	Every 12 months	Every 12 months
• Frames	Every 12 months	Every 12 months
• Contact Lenses	Every 12 months	Every 12 months

Your payroll contributions for vision benefits are shown here.

Vision	Bi-Weekly
Employee Only	$2.47
Employee + 1	$4.70
Family	$6.91

LIFE INSURANCE AND AD&D

The Company provides basic life and AD&D insurance for employees and offers voluntary insurance options for employees and their dependents.

Basic Life and AD&D Insurance

Life insurance is an important part of your financial wellbeing, especially if others depend on you for support. The Company provides basic life and accidental death and dismemberment insurance at **no cost** equal to 2 times your base annual earnings, up to a maximum of $500,000. Coverage is automatic. You do not need to enroll. Please be sure to contact Human Resources if you have a change of beneficiary.

Employer provided life insurance amounts of $50,000 or greater are subject to imputed income tax, per IRS guidelines.

Voluntary Life and AD&D Insurance

You may choose to purchase additional life and AD&D coverage for you and your dependents at affordable group rates. Rates are based on age and the coverage level chosen.

Voluntary Life and AD&D Insurance for you

Employee

- Increments of $10,000 up to 5x your base annual salary
- Up to a $500,000 maximum
- Guaranteed issue up to $300,000

Voluntary Life for Employees and/or Dependents

Spouse

- Increments of $5,000 (not to exceed 50% of your voluntary life and AD&D coverage) and employee must elect in order to elect for spouse
- Up to a $250,000 maximum
- Guaranteed issue up to $50,000
- The spouse rate and age reductions are based on the employee's birth date.

Child(ren)

- $5,000 per child from birth to age 26; one premium will insure coverage for all eligible children.

Evidence of insurability is required for amounts over the guaranteed issue or if you apply for coverage outside of your window of eligibility and is subject to carrier approval.

Voluntary Term Life Insurance Rates for Employee & Spouse

Age	Employee Rate Per $1,000/Month	Age	Employee Rate Per $1,000/Month
0-24	$0.085	**50-54**	$0.356
25-29	$0.076	**55-59**	$0.551
30-34	$0.085	**60-64**	$0.831
35-39	$0.102	**65-69**	$1.450
40-44	$0.136	**70-99**	$3.357
45-49	$0.229		

Voluntary Accidental Death and Dismemberment (AD&D)

Employee - Increments of $10,000 to the lesser of 5x salary or $500,000. Age reduction: benefits reduce to 65% at age 70 and 50% at age 75.

Elections for dependents cannot exceed 50% of employee benefit.

Spouse - $10,000 increments to $250,000

Child(ren) - increments of $5,000 to $50,000. Children are covered from birth to age 26.

The monthly premium for Voluntary AD&D for Employee, Spouse or Child(ren) is $0.30 per $1,000 of coverage.

DISABILITY

Disability Insurance

Disability insurance provides income replacement should you become disabled and unable to work due to an illness or injury not related to work. The Company provides disability coverage as shown below.

Short-Term Disability is voluntary. The premium is paid by you, the employee. There is a new voluntary Short Term Disability plan effective January 1, 2022. The company paid Short-Term Disability will be terminating as of 12/31/21. If you want to continue coverage for voluntary Short-Term Disability, you must elect this coverage during open enrollment, or upon your initial eligibility. If you do not elect during initial eligibility or at open enrollment (either this year or at any future open enrollment), your election is not guaranteed and will require proof of good health and insurance carrier approval. The voluntary STD includes a pre-existing condition limitation and applies to claims filed in the first year of coverage. There is a 3 month look back for any diagnosis or treatment in the 3 months prior to effective date of coverage. Cigna is providing a credit for time served for those currently insured today under the employer paid plan.

The Long-Term Disability coverage is paid for by the Company. You will be enrolled automatically, upon meeting eligibility requirements.

Coverage	Benefit
Voluntary Short-Term Disability	• 60% of your weekly salary to a maximum of $1,500 per week for the first 90 days of a disability after the 14-day waiting period.
Long-Term Disability	• 60% of your base salary to a maximum of $21,000 per month if you are disabled and are unable to work for more than 90 days. • Benefits are offset with other sources of income, such as Social Security and Workers' Compensation.

To calculate the premium for Voluntary Short-Term Disability, please see the calculation below:

(.31/10) x ($ use your salary here/52) x .60 = Monthly Premium

Sample Salary: $74,000

Voluntary Short-Term Disability Rate: $0.31

Benefit: 60% of weekly salary

Using the sample salary, see below:

(.31/10) x ($74,000/52) x .60 = $26.47 per month

EMPLOYEE ASSISTANCE PROGRAM

Life | Work Balance

As working professionals, we are faced with meeting both personal and professional commitments. At Chesapeake Utilities Corporation, we are aware of the many demands on our employees. After all, life is a balancing act. We are committed to fostering a productive and healthy workforce. We recognize the importance of a Life-Work balance and how it relates to your total health and well being.

Our wellness program provides tools and resources to help you achieve and maintain a healthy Life - Work balance.

Employee Assistance Program

Employee Assistance Program (EAP)

Life can present complex challenges. You and your family have access to simple solutions to help you cope with stress and life challenges through the Employee Assistance Program. The Company offers two EAP services at no cost to you.

Wood & Associates' Employee Assistance Program offers confidential support at no-cost to you or your family members, regardless of benefit elections. The program includes emotional or work-life counseling with up to three face-to-face visits, financial information and resources, and legal support and resources. **Confidential assistance is available anytime by calling 800-343-4670.**

Cigna's Life Assistance Program is a confidential, no-cost telephonic resource available to you and your family regardless of benefit elections. The program includes emotional or Life-Work counseling with up to three face-to-face visits, financial information and resources, and legal support and resources. **For 24/7 support, log on to www.cignalap.com or call 800-538-3543.**

- **Emotional or Work-Life Counseling** helps address stress, relationship or other personal issues you or your family members may face including: job pressures, stress, anxiety and depression, substance abuse, relationship/marital conflicts, work/school disagreements, and childcare/eldercare referral services.
- **Financial Information and Resources** provides support for the complicated financial decisions you or your family members may face. Speak by phone with a Certified Public Accountant and Certified Financial Planners on a wide range of financial issues including: managing a budget, getting out of debt, saving for college or retirement, and tax questions.
- **Legal Support and Resources** offers assistance if legal uncertainties arise. Talk to an attorney by phone about the issues that are important to you or your family members including: debt and bankruptcy, buying a home, divorce, guardianship, and power of attorney.

Tuition Reimbursement Plan

We are committed to the development of our employees and encourage employees to obtain a higher education related to their job functions. The Tuition Reimbursement plan is designed to help employees obtain additional education or a degree program to include an associate's, bachelor's or master's degree to increase their competence in the present position and prepare for potential opportunities with the Company.

This benefit applies to employees with at least six months of continuous employment. It is required for an employee's performance level to be evaluated at "meets expectations" or higher at the time of request. Employees on a Performance Improvement Plan (PIP) are not eligible to participate. An employee who is placed on a PIP during the completion of a previously approved course will receive reimbursement for the course, and will be ineligible to apply for further reimbursement until the performance level has met the minimum "meets expectations." If a master's degree is sought, the employee must be in good standing, and requires a performance level to be evaluated at "exceed expectations."

The Company will reimburse for books, tuition and registration up to the limit of $5,250 per calendar year (non-taxable limit). Courses must be taken at an accredited post-secondary institution by the Council for Higher Education Accreditation (CHEA) or the Middle States Commission on Higher Education (DE, MD, & PA) or the commission on Colleges of the Southern Association of Colleges and Schools (FL, VA, GA, and TX). Any exception to schools that are not listed in the above accreditation bodies must have a signed approval from the AVP of Human Resources.

Undergraduate courses must have a grade of a "C" or better to be reimbursed for eligible expenses within the degree program. Graduate courses must have a grade of a "B" or better to be reimbursed for eligible expenses within the degree program.

Employees must continue their service with the Company for an additional 12 months after their last class or graduation. If an employee voluntarily leaves the company within 12 months of graduation or their last class, they must reimburse the Company 50% of all tuition expenses that were paid on their behalf for the preceding 12 months.

401(k) RETIREMENT SAVINGS PLAN

Whether you are close to retirement or not, it's important to have savings goals and specific investment objectives at any point in your lifetime. To assist with meeting your goals and objectives, we offer a 401(k) Retirement Savings Plan, administered by Fidelity, with multiple investment options and a company match. Key details and features of our plan are listed below.

The company offers both a traditional pre-tax option as well as a Roth post-tax option.

Employee contributions	Employer contributions
You can contribute up to $20,500 in 2022, and if you are age 50 or older, you may contribute up to an additional $6,500 as a "catch-up" contribution. Contributions may be made on a pretax or Roth after-tax basis. To make it easier for you to save, the plan offers annual savings adjustments to help you to automatically set aside extra money. Your savings rate will increase 1% each year until you reach 10%.	The Company will match up to 6% of your contribution and may also make additional supplemental contributions to your account.

Vesting

Vesting refers to your ownership of the money in your 401(k). You will be 100% vested in the company match after two years of service. You are always 100% vested in your contributions to the plan.

Roth 401k

A Roth contribution is another way to save money through the retirement plan. With a Roth, you can make contributions on an after-tax basis. Roth contributions provide you with the opportunity to invest after-tax dollars, enabling your investments to grow tax-deferred during your working years. At retirement, you are permitted to withdraw the funds free of federal tax.

Features of 401k:

- Automatic Payroll Contributions
- Catch-Up Contributions (age 50 or older)
- Employer Contributions - the Company matches up to 6% of compensation
- Auto Enrollment/Auto Escalation - upon eligibility, if you do not participate (and don't formally opt out), you will be automatically enrolled with a 3% election. If you make no changes to this automatic enrollment, the auto escalation feature will increase the contribution by 1% each year.
- Variety of Investment Options and Flexibility
- Early Access - you may be able to withdraw or borrow from your account, subject to early withdrawal or borrow requirements.
- Personal Statements - issued quarterly

More Information

- You can enroll in the plan and make changes to your contributions at any time
- Fidelity has many different investment options for you to choose, along with tools and resources you can use to determine which options best meet your investment objectives.

For additional details about the 401(k) Retirement Savings Plan or to enroll or change your contribution rates or investment elections, visit www.netbenefits.com or call 800-835-5095.

DIVIDEND REINVESTMENT & DIRECT STOCK PURCHASE PLAN

We offer employees the opportunity to purchase Chesapeake Utilities Corporation (NYSE: CPK) common stock through payroll deductions without incurring brokerage fees for purchases or account maintenance. Employees can join the Company's Dividend Reinvestment & Direct Stock Purchase Plan (DR/DSPP) by having payroll deductions each pay period. Payroll deductions must be at least $50 per quarter so the minimum bi-weekly deduction would be $9. This is only a minimum deduction. You may elect to have a higher amount deducted if you prefer, and you can change payroll deductions or stop at any time.*

Your payroll dollars are invested monthly on the investment date (typically the fifth of each month or on the next business day if the fifth falls on a weekend or a holiday). Shares are either issued from a designated Company reserve or purchased on the open market. If the shares are issued from the reserve, the cost basis of the shares is the average of the high and low trading prices on the investment date. If purchased on the open market, the cost basis of the shares is the weighted average market price of the specific batch of shares purchased by the Plan Administrator's broker on the investment date. For each month that you have activity in your account, you will receive a plan statement from Computershare (the Company's transfer agent) showing the number of shares purchased and the associated cost basis of those shares.

The payment of a dividend is determined by our Board of Directors each quarter. Upon their approval, dividends are typically paid quarterly on the fifth day of January, April, July and October (or the next business day if the fifth falls on a weekend or a holiday). If you participate in payroll deductions, your quarterly dividends will be automatically reinvested into additional shares of common stock. You can contact Computershare directly with questions regarding your account using the contact information below, or you can access your account electronically by creating an online account by visiting www.computershare.com/investor.

Computershare Trust Company, N.A.
c/o Chesapeake Utilities Corporation
P.O. Box 505000, Louisville, KY 40233-5000
Telephone: 877-498-8865 (U.S. and Canada)
781-575-2879 (outside of the U.S. and Canada)
Internet: www.computershare.com/investor

To invest in CPK common stock via payroll deductions, you can contact your local payroll department for the "Payroll Deduction Authorization Form," or you may also go to UltiPro and select "Payroll Deduction Authorization Form" under the section, Chesapeake Stock Purchase Plan. Print the form or complete it electronically and forward it to Heidi Watkins, Shareholder Services Manager; hwatkins@chpk.com. Your payroll deductions will start within approximately two weeks of returning the completed form. Changes and cancellations can be made by submitting an updated version of this form.

For further information on the DR/DSPP, or if you have any questions regarding the plan, please contact Heidi Watkins at 302-734-6716 or hwatkins@chpk.com.

*For Officers and other designated employees who may have access to material non-public information based on their job functions, there are set times when payroll deductions can and cannot be changed or stopped in conjunction with the Insider Trading Policy and the trading window. Please contact Heidi Watkins if you have any questions.

GLOSSARY

Brand Preferred Drug – A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.

Brand Non-Preferred Drugs – A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs.

Calendar Year Maximum – The maximum benefit amount paid each year for each family member enrolled in the dental plan.

Coinsurance – The sharing of cost between you and the plan. For example, 80% coinsurance means the plan covers 80% of the cost of service after a deductible is met. You will be responsible for the remaining 20% of the cost.

Copay – A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible – The amount you have to pay for covered services each year before your health plan begins to pay.

Elimination Period – The time period between the beginning of an injury or illness and receiving benefit payments from the insurer.

Flexible Spending Account (FSA) – An FSA allows you to pay for qualified health care expenses for you, your spouse and dependents, using tax-free dollars. The money in the account is subject to the "use it or lose it" rule, which means you must spend the money in the account before the end of the plan year.

Generic Drugs – A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.

Health Savings Account (HSA) – An HSA is a personal savings account for those enrolled in a High Deductible Health Plan (HDHP). You may use your HSA to pay for qualified medical expenses, including deductible and coinsurance expenses, prescription drugs, dental care and vision care. You can use the money in your HSA to pay for qualified medical expenses now, or in the future, and those of your legal spouse and dependents, even if they are not covered by the HDHP.

High Deductible Health Plan (HDHP) – A qualified High Deductible Health Plan (HDHP) is defined by the Internal Revenue Service (IRS) as a plan with a minimum annual deductible and a maximum out-of-pocket limit. These minimums and maximums are determined annually and are subject to change.

In-network – A designated list of health care providers (doctors, dentists and etc.). with whom the insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the Company.

Inpatient – Services provided to an individual during an overnight hospital stay.

Mail Order Pharmacy – Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

Out-of-network – Providers not in the plan's network. The cost of services provided by out-of-network providers could be much higher compared to in-network providers. Higher deductibles and coinsurance will apply. Out-of-network providers do not participate in the medical carrier network and you may be balance billed.

Out-of-pocket Maximum – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.

Outpatient – Services provided to an individual at a hospital facility without an overnight hospital stay.

Primary Care Provider (PCP) – A doctor (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.

Reasonable & Customary Charges (R&C) – Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. R&C may apply to out-of-network charges.

Specialist – A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist or neurologist).

CONTACT INFORMATION

Health Benefits	Highmark Blue Cross Blue Shield of Delaware	Benefits Customer Service Website Login Setup AllClear ID Theft Member Service Website	(800) 633-2563 (877) 298-3918 *8am - 6pm EST. Mon-Fri* (866) 584-9479 (DB21752) https://www.highmarkbcbsde.com www.Express-Scripts.com
	Delta Dental (Dental Insurance)	Benefits Customer Service (USA) Benefits Customer Service (DE, MD, PA) Benefits Customer Service (FL) Member Service Website	(800) 422-4234 (TTY/TDD 711) *8:00 am to 9:00 pm ET, Mon-Fri* (800) 932-0783 (TTY/TDD 711) (800) 521-2651 (TTY/TDD 711) *8:00 am to 8:00 pm, EST, Mon-Fri* www.deltadentalins.com
	EyeMed (Voluntary Vision Insurance)	Benefits Customer Service Lasik Customer Service Member Service Website	(866) 804-0982 (800) 988-4221 www.eyemed.com www.eyemed.com/member
	Employee Benefits Corporation (Flexible Spending Account (FSA) & Health Savings Account (HSA))	Benefits Customer Service Member Service Website	(800) 346-2126 or email at participantservices@ebcflex.com www.ebcflex.com *7:00 am to 7:00 pm CST, Mon-Fri*
Life, Ad&D and Disability	CIGNA/New York Life Life, AD&D, Short or Long Term Disability	Benefits Customer Service Member Service Website	(800) 362-4462 (866) 562-8421 Español www.cigna.com *7:00 am to 7:00 pm CST, Mon-Fri*
FMLA	FMLASource (FMLA claims)	Benefits Customer Service Member Services Website	(877)GO2.FMLA (462-3652) www.fmlasource.com *7:30 am to 9:30 pm CST, Mon-Fri*
Retirement	Fidelity (401(k)) Computershare Trust Company, N.A. *(Dividend Reinvestment & Direct Stock Purchase Plan)*	Benefits Customer Service Member Service Website Benefits Customer Service Member Service Website	(800) 835-5095 www.netbenefits.com (887) 498-8865 https://www-us.computershare.com/Investor
Employee Assistance	New York Life Wood & Associates	Benefits Customer Service Member Services Website Benefits Customer Service Member Services Website	(800) 538-3543 www.nylgbs-lap.com (800) 343-4670 www.woodassociates.net

CONTACT INFORMATION

Human Resources Team			
William Hughston	Vice President and Chief Human Resources Officer	302-382-5253	whughston@chpk.com
Devon Rudloff	Assistant Vice President, Human Resources	813-335-0088	drudloff@chpk.com
Ruth Warner	Director, Human Resource Operations	302-213-7301	rwarner@chpk.com
Tina Barrington	HR Manager	904-430-4731	tbarrington@chpk.com
Meredith Sebastian	HR Manager	302-736-7649	msebastian@chpk.com
Shaun Waller	HR Business Partner	302-316-7035	swaller@chpk.com
Lacey Priestley	HR Business Partner	302-736-7875	lpriestley@chpk.com
Dina Bellechases	Compensation & Retirement Manager	561-232-7068	dbellechases@chpk.com
Renee Bolyard	HR Coordinator	904-510-4701	rbolyard@chpk.com
Michelle Conkey	HRIS Analyst	302-382-8935	mconkey@chpk.com
Melanie Ryder	Employee Engagement Coordinator	302-272-3752	mryder@chpk.com
Brian Apple	HR Business Partner	813-597-3013	bapple@chpk.com
Miriam Castro	HR Business Partner	561-398-9015	mcastro@chpk.com
Missy Dalrymple	HR Business Partner	850-348-9490	mdalrymple@chpk.com
Investor Relations Team			
• **Heidi Watkins**	Shareholder Services Manager	302-734-6716	hwatkins@chpk.com

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HIPAA Special Enrollment Rights – If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the health coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

Section 111 – Effective January 1, 2009 Group Health Plans are required by Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension of 2007's new Medicare Secondary Payer regulations. The mandate is designed to assist in establishing financial liability of claim assignments. In other words, it will help establish who pays first. The mandate requires Group Health Plans to collect additional information, more specifically Social Security numbers for all enrollees, including dependents six months of age or older. Please be prepared to provide this information on your Benefit Enrollment Form when enrolling into benefits.

Women's Health and Cancer Rights Act of 1998 – If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedma

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

The Newborn's and Mother's Health Protection Act – Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

Patient Protection: If the Group Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

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It is your responsibility to ensure that the information provided on your application for coverage is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a U.S. state listed below, contact your state Medicaid or CHIP office to learn if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to learn how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your state for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442

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ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/ hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

NEBRASKA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

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MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740.
TTY: Maine relay 711

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

VERMONT – Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924 CHIP
Phone: 1-800-432-5924

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

ANNUAL NOTICES

PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HI PP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

MEDICARE D NOTICE

Important Notice from Chesapeake Utilities Corporation (CUC) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CUC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **CUC has determined that the prescription drug coverage offered by Highmark Blue Cross Blue Shield Delaware is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

If you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Company coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Company coverage, be aware that you and your dependents may not be able to reclaim any coverage.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with CUC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may increase by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

MEDICARE D NOTICE

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll receive this notice each year. You will also receive this notice prior to the next enrollment period to join a Medicare drug plan, and if this coverage through CUC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage...

Visit www.medicare.gov
Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the telephone numbers) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 15, 2021
Name of Entity/Sender: Chesapeake Utilities Corporation
Office: Human Resources
Address: 500 Energy Lane, Suite 500, Dover, Delaware 19901

About this Guide

This benefit summary provides selected highlights of the Chesapeake Utilities Corporation benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Chesapeake Utilities Corporation reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.