Benefits

Health is Wealth

EMPLOYEE BENEFITS GUIDE 2025

infoblox

CONTENTS

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

GETTING STARTED

2025 Benefits

January 1, 2025 through December 31, 2025

No matter where you are in your career, Infoblox supports you with benefit programs and wellbeing resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, as well as life, disability, retirement, voluntary options, and wellness programs.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life.

Take a look at what's available to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

Employees who work at least 30 hours per week are eligible to enroll in benefits. Most benefits are effective on your date of hire as long as you enroll within 30 days of your date of hire.

Eligible dependents

- Your legal spouse
- Your same or opposite gender domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit
- Your children (including your domestic partner's children):
    - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support. You will need to designate in Workday and provide a physician statement.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

When you can enroll

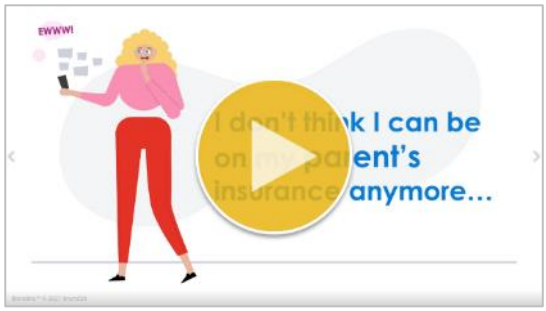
New employees can enroll after your date hire, but you must enroll within 30 days of becoming eligible. Existing employees can enroll during the annual open enrollment period.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment.

If you do not enroll in benefits, the only coverage you will have for the remainder of the plan year is company-provided Basic Life, Basic AD&D, Short and Long-Term Disability.

CHANGING YOUR BENEFITS

Click to play video



Life happens

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Generally, you may only make or change your existing benefit elections as a new hire or during the annual open enrollment period.

Make sure to notify the Benefits Team right away if you have a qualifying life event and need to make a change (add or drop) to your coverage election. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Marriage
- Divorce
- Emergency contact information
- Address changes

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).

ENROLLING FOR BENEFITS

Do I need to enroll?

Yes, you need to enroll in the benefit options you want. Be sure to select applicable information, like dependents and beneficiaries.

During open enrollment, you will need to re-elect your health savings account (HSA) and flexible spending account (FSA) options.

Before you enroll

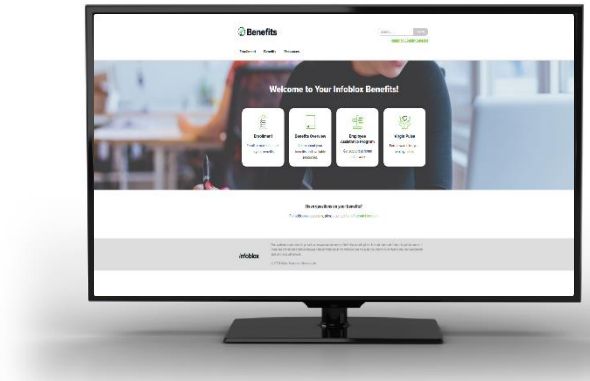
- Review your enrollment materials to understand your benefit options and costs for the coming year.
- Covering a dependent? Go to Benefits in PeopleHub, then click on **Before You Enroll**.

- For every dependent you cover:
  - Enter Date of Birth in **Biographical Info**.
  - Enter Social Security Number or TIN in **National Identifiers** for spouse or domestic partner.

Enrollment tools & resources

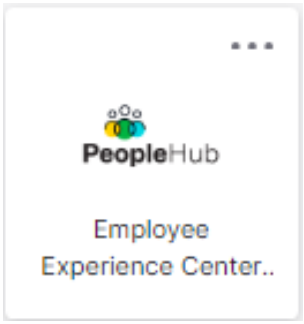
Infoblox Benefits Portal: infobloxbenefits.com

- Learn about Infoblox's available benefit plans and wellness programs.



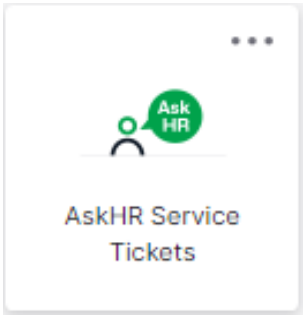
PeopleHub: infoblox.okta.com

- Make benefit elections, enter dependents and beneficiaries and report life events.



Have questions about your benefits?

Submit a ticket: AskHR tile /Benefits (log in required)
Email: benefits@infoblox.com



HEALTHCARE

Our commitment

We believe our employees should have access to healthcare coverage that promotes preventive care and helps cover the cost of illness.

Eligible employees and their dependents can enroll in medical, dental, and vision coverage through the Infoblox benefits program.

Medical

We offer two Cigna plans (available to all U.S. employees) and two Kaiser plans (available in California only) so you can choose the best fit for your health concerns and budget.

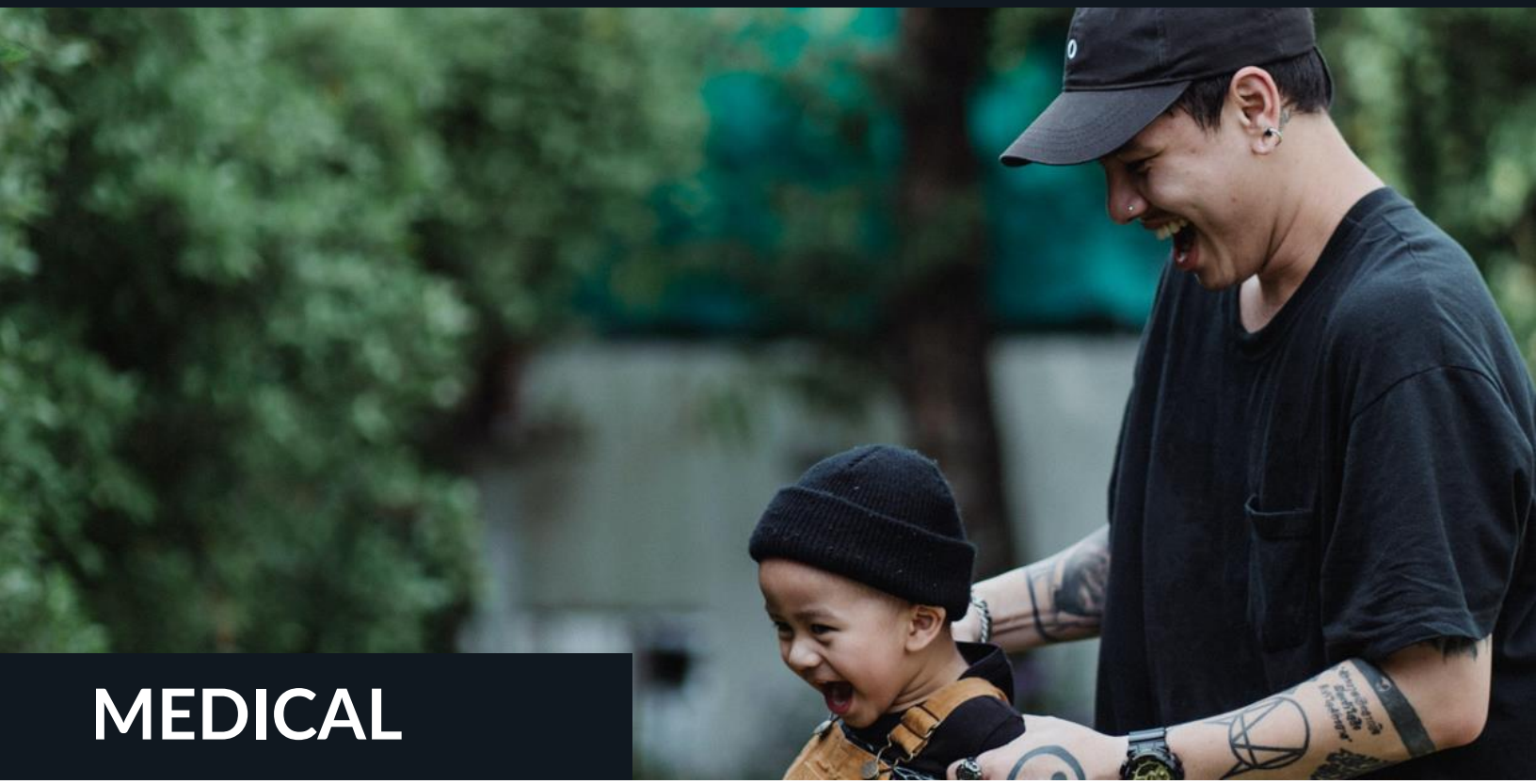
Dental

Regular checkups and cleanings are fully covered if you use a participating provider. If you do need more care, insurance helps cover the cost for fillings, gum disease, orthodontia, and more.

Vision

Our vision plan helps cover the cost of eye exams, eyeglasses, and contact lenses to ensure you're seeing and feeling your best.

Make time for health



MEDICAL

Words to know

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

Click to play video

- **Deductible:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **Out-of-Pocket maximum:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **Coinsurance:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **Copay:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **In-Network / Out-of-Network:** In-Network services will always be the lowest cost option. Out-of-Network services will cost more or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

WHICH MEDICAL PLAN IS RIGHT FOR YOU?

Consider a High Deductible Health Plan (HDHP) if:

- You want tax-free savings on your healthcare costs .
- You want to build a savings account for future healthcare. costs for you and your eligible family members.
- You want an extra way to add to your retirement savings.

Plans To Consider

- Cigna OAP HDHP
- Kaiser HDHP (CA Only)

Consider a PPO (preferred provider organization) if:

- You want to be able to see any provider, even a specialist, without a referral.
- You want coverage for Out-of-Network providers (at a higher cost).

Plans To Consider

- Cigna OAP PPO

Consider an HMO (health maintenance organization) if:

- You want lower, predictable out-of-pocket costs.
- You like having one doctor to manage your care.
- You are happy with the selection of network providers.
- You don't see any doctors that are Out-of-Network.
- You have convenient access to Kaiser facilities.

Plans To Consider

- Kaiser HMO (CA Only)
- Kaiser HDHP (CA Only)

CIGNA OAP HDHP

The coinsurance (%) shows what you pay after the deductible.

Medical	In-Network	Out-of-Network[3]
Calendar Year Deductible	Individual: $2,000 Family: $4,000[1]	Individual: $4,000[2] Family: $8,000[2]
Calendar Out-of-Pocket Maximum[3] (includes Deductible)	Individual: $4,000 Family: $8,000	Individual: $8,000 Family: $16,000
Preventive Care	No charge	You pay 30%*
Office Visit, Primary Care Physician	You pay 10%*	You pay 30%*
Office Visit, Specialist	You pay 10%*	You pay 30%*
Lab and X-ray	You pay 10%*	You pay 30%*
Urgent Care	You pay 10%*	You pay 10%*
Emergency Room	You pay 10%*	You pay 10%*
Inpatient Hospitalization	You pay 10%*	You pay 30%*
Outpatient Surgery	You pay 10%*	You pay 30%*
Retail Pharmacy (30-day supply)	**In-Network**	**Out-of-Network**
Generic (Tier 1)	You pay 10%*	You pay 30%*
Preferred Brand (Tier 2)	You pay 10%*	You pay 30%*
Non-Preferred Brand (Tier 3)	You pay 10%*	You pay 30%*
Specialty (Tier 4)	You pay 10%*	You pay 30%*
Mail Order Rx (90-day supply)	**In-Network**	**Out-of-Network**
Generic (Tier 1)	You pay 10%*	Not covered
Preferred Brand (Tier 2)	You pay 10%*	Not covered
Non-Preferred Brand (Tier 3)	You pay 10%*	Not covered
Specialty (Tier 4)	You pay 10%*	Not covered

*After deductible.

1. Entire family deductible must be met prior to benefits being paid for any family members.
2. Entire out-of-pocket max must be met prior to plan paying 100% of covered charges for any family members.
3. Some Out-of-Network services require precertification. A 50% penalty is charged if Out-of-Network precertification is not completed.

CIGNA OAP PPO

You always pay the copayment ($). The coinsurance (%) shows what you pay after the deductible.

Medical	In-Network	Out-of-Network[2]
Calendar Year Deductible	Individual: $750 Family: $750 per individual, up to $2,250	Individual: $1,500[1] Family: $1,500 per individual, up to $4,500[1]
Calendar Out-of-Pocket Maximum[2] (includes Deductible)	Individual: $3,000 Family: $3,000 per individual, up to $6,000	Individual: $10,000 Family: $10,000 per individual, up to $20,000
Preventive Care	No charge	You pay 30%*
Office Visit, Primary Care Physician	$20 copay	You pay 30%*
Office Visit, Specialist	$30 copay	You pay 30%*
Lab and X-ray	You pay 10%*	You pay 30%*
Urgent Care	$35 copay*	$35 copay*
Emergency Room	$100 copay* waived if admitted	$100 copay* waived if admitted
Inpatient Hospitalization	You pay 10%*	You pay $500 per admission plus 30%*
Outpatient Surgery	You pay 10%*	You pay 30%*
Retail Pharmacy (30-day supply)	**In-Network**	**Out-of-Network**
Generic (Tier 1)	$15 copay	You pay 50%
Preferred Brand (Tier 2)	$30 copay	You pay 50%
Non-Preferred Brand (Tier 3)	$50 copay	You pay 50%
Specialty (Tier 4)	You pay 20%	You pay 50%
Mail Order Rx (90-day supply)	**In-Network**	**Out-of-Network**
Generic (Tier 1)	$30 copay	Not covered
Preferred Brand (Tier 2)	$60 copay	Not covered
Non-Preferred Brand (Tier 3)	$100 copay	Not covered
Specialty (Tier 4)	You pay 20%	Not covered

*After deductible.

1. Combined with In-Network.
2. Some Out-of-Network services require precertification. A 50% penalty is charged if Out-of-Network precertification is not completed.

KAISER PLANS – CA ONLY

You always pay the copayment ($). The coinsurance (%) shows what you pay after the deductible.

Medical	Kaiser HDHP (In-Network Only)	Kaiser HMO (In-Network Only)
Calendar Year Deductible	Individual: $2,000 Family: $3,300 per individual, up to $4,000 per family	Individual: None Family: None
Calendar Out-of-Pocket Maximum (includes Deductible)	Individual: $3,600 Family: $3,600 per individual, up to $7,200	Individual: $1,500 Family: $1,500 per individual, up to $3,000
Preventive Care	No charge	No charge
Office Visit, Primary Care Physician	$30 copay*	$20 copay
Office Visit, Specialist	$50 copay*	$20 copay
Lab and X-ray	$10 copay*	No charge
Urgent Care	$30 copay*	$20 copay
Emergency Room	$200 copay* (waived if admitted)	$50 copay (waived if admitted)
Inpatient Hospitalization	$250 copay*	$250 copay
Outpatient Surgery	$150 copay*	$20 copay
Retail Pharmacy (30-day supply)	**Kaiser HDHP (In-Network Only)**	**Kaiser HMO (In-Network Only)**
Generic (Tier 1)	$10 copay*	$10 copay
Preferred Brand (Tier 2)	$30 copay*	$25 copay
Non-Preferred Brand (Tier 3)	$30 copay*	$25 copay
Specialty (Tier 4)	You pay 20%* up to $250 per prescription	You pay 20% up to $150 per prescription
Mail Order Rx (100-day supply)	**Kaiser HDHP (In-Network Only)**	**Kaiser HMO (In-Network Only)**
Generic (Tier 1)	$20 copay*	$20 copay
Preferred Brand (Tier 2)	$60 copay*	$50 copay
Non-Preferred Brand (Tier 3)	$60 copay*	$50 copay
Specialty (Tier 4)	You pay 20%* up to $250 per prescription	You pay 20% up to $150 per prescription

*After deductible.

HEALTH SAVINGS ACCOUNT (HSA)

Click on the video to play it

Four reasons to love an HSA

1. **Tax-free.** No federal or state tax (in most states) on contributions, interest, and investment growth. Withdrawals are tax-free for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save (and invest!) the money to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free. You can also use it for regular living expenses, which will be taxable but without penalties.

Save for healthcare expenses

A **Health Savings Account (HSA)** is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

How does an HSA work?

- Your HSA account is set up automatically on the first day of the month following your submitted enrollment.
- You must enroll in the HSA plan in **PeopleHub** as a separate step after electing either the Cigna or Kaiser HDHP medical plan option.
- Each year, Infoblox contributes to your HSA (not prorated).

Individual: $500
Family: $1,000

- You can contribute up to the IRS annual limit (displayed amount includes Infoblox employer contribution).

Individual: $4,300 per year
Family: $8,550 per year

Have you celebrated age 55?
Contribute an extra $1,000 per year!

- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.
- Forgot your card? Save your receipt and submit eligible expenses for reimbursement as either a paper check or direct deposit.

See below to learn more:
Eligible Expenses
Ineligible Expenses

Are you eligible?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the Cigna OAP HDHP or the Kaiser HDHP.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses (not available at Infoblox).

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

Are you eligible?

You don't have to enroll in one of our medical plans to participate in the Healthcare FSA.

Find out more

- Eligible Expenses – now includes more over-the-counter items!
- Ineligible Expenses

Do you pay for dependent care?
Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the Infoblox Healthcare FSA works

- Estimate what you and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and even eligible drugstore items.
- You can contribute up to **$3,300**, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you forfeit the leftover balance at the end of the year. You are not able to change your election mid-year unless you experience a qualifying event.

FSA TAX SAVINGS EXAMPLE (SINGLE FILERS)

$60,000 Annual Pay, with $1,700 FSA Contribution

$374 22% Federal income tax	**$130** 7.65% FICA tax	**$504** Annual FSA tax savings

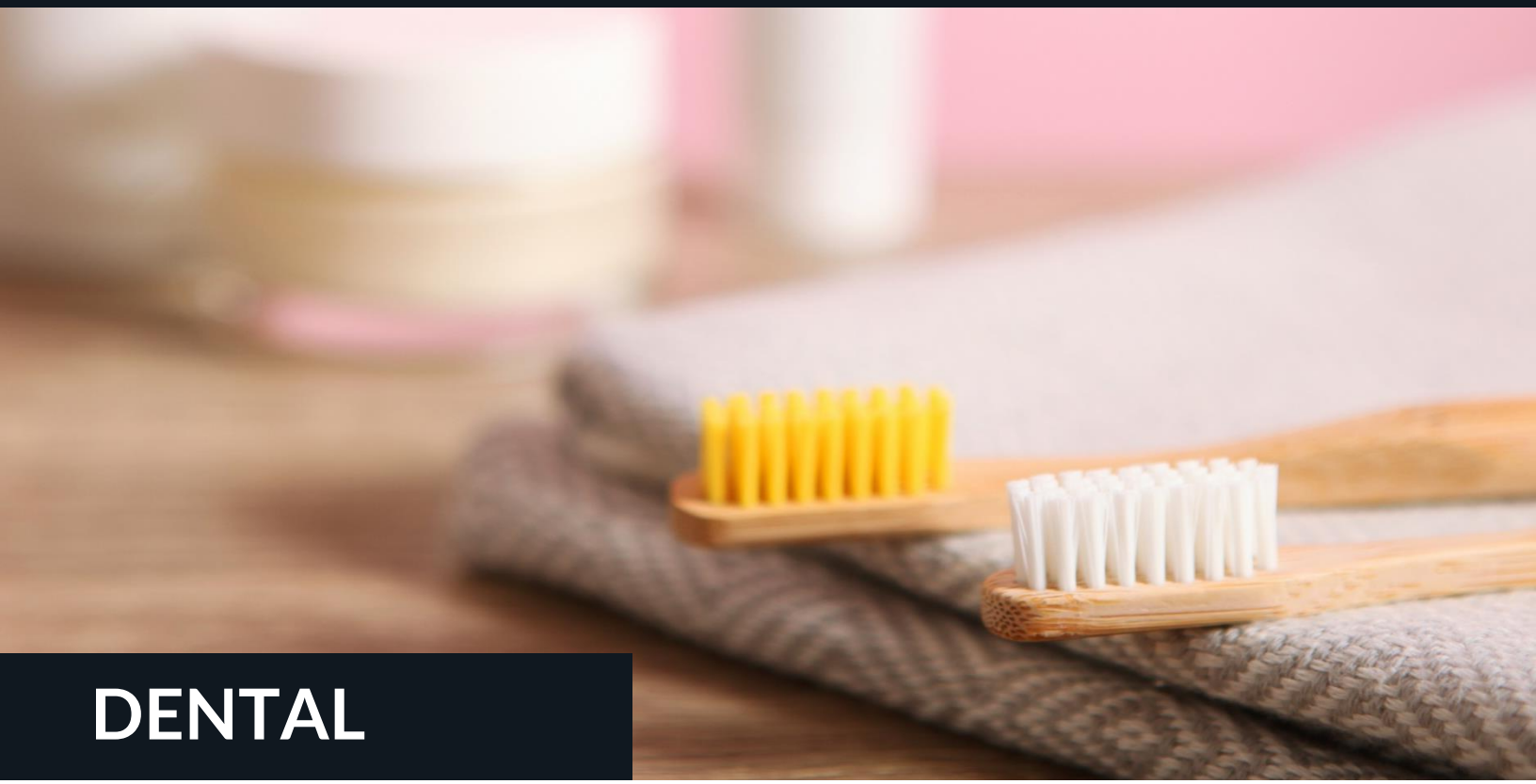
$120,000 Annual Pay, with $3,000 FSA Contribution

$792 24% Federal income tax	**$252** 7.65% FICA tax	**$1,044** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

WHAT'S THE DIFFERENCE? FSA vs. HSA

	Healthcare FSA	HSA
Stands for	Flexible Spending Account	Health Savings Account
Who is eligible?	Employees in the PPO or HMO plans	Members enrolled in a High Deductible Health Plan (HDHP) who do not have any other non-HDHP health plan, such as Medicare or a spouse's plan.
Contribution limits*	Healthcare FSA: $3,300	*Includes Infoblox's contribution Single coverage: $4,300 Family coverage: $8,550
Who owns the account?	Infoblox	You
Contributions subject to income tax?	No	No
Does interest accrue?	No	Yes
Contributions	Money is deducted (pre-tax) from your paycheck every pay period. Additional contributions are NOT allowed.	Money is deducted (pre-tax) from your paycheck every pay period. Additional contributions up to the maximum contribution amount ARE allowed.
Disbursement of funds	In most cases, the entire annual contribution amount is available from the beginning of the year.	Only funds paid in by you are available.
Catch-up contribution for age 55+	No	Yes. Members age 55+ may contribute up to $1,000 more to their account per year.
Portability and Forfeiture	You lose any unspent money when employment is terminated.	This account is portable. HSA balance is not forfeited when you change employers or health plans.
Expiration	Unused money in an FSA expires and is lost at the end of the year.	Your funds never expire.
Balance carry over (or rollover)	No, you must use it or lose it.	Yes. Unused funds are carried over to the following year.
Can I change my contribution?	Only for Qualifying Life Events, such as a marriage, divorce, birth, or during Open Enrollment.	Yes, on a pay period basis.
Eligible medical expenses	Eligible expenses such as medical copays, coinsurance, deductibles, eyeglasses, over-the-counter medications prescribed by your doctor.	Medical, dental, vision and prescription drug expenses incurred by you and your eligible family members.
Proof of expenses required?	Yes	No. However, you should be prepared to substantiate to the IRS that the expense has been incurred, the amount of the expense, and its eligibility.



DENTAL

Our plan

Cigna Dental PPO

Why sign up for dental coverage?

Brushing and flossing are great, but regular exams catch dental issues early. If there's a problem, our dental plan makes it easier and less expensive to get the care you need to maintain your smile.

Find out how it works!

Click to play video

CIGNA DENTAL PPO

You always pay the deductible except for diagnostic & preventive care. The coinsurance (%) shows what you pay after the deductible.

Dental	In-Network	Out-of-Network
Annual Deductible	Individual: $50 Family: $150	
Annual Plan Maximum Benefit	$2,000 per individual (Basic and Major Services combined)	
Diagnostic & Preventive	No charge	No charge[1]
Basic Services	You pay 10%*	You pay 20% after deductible[1]
Major Services	You pay 30%*	You pay 40% after deductible[1]
Orthodontia for Children & Adults	You pay 50%*	You pay 50% after deductible[1]
Ortho Lifetime Max	$1,500	$1,500

[1]Should you receive Out-of-Network services, you will be responsible for charges in excess of the Reasonable and Customary (R&C) charge of 90th percentile and charges for non-covered services.

Details about the dental plan

Type of Plan	Preferred Provider Organization (PPO)
Features	See any provider, but you'll pay more Out-of-Network
Am I restricted to in-network providers?	No
Do I have to select a primary dentist?	No
Can I use my HSA or FSA?	If you participate in a healthcare HSA or FSA, you can use your account to pay for dental expenses.
How do I get more information?	myCigna.com or myCigna mobile app

VISION

Our plan

VSP Vision

Click to play video

Why sign up for vision coverage?

Even if you have 20/20 vision, an annual eye exam checks the health of your eyes and can detect other health issues. If you do need glasses or contacts, vision coverage helps with the cost.

Visit the plan's website for extra savings on services like LASIK and PRK, and rebates on contact lenses.

VSP VISION

Your vision checkup is fully covered after your Exam copay. After your Materials copay, the plan covers frames, lenses, and contacts as described below.

Traditional Vision Care	In-Network / Participating Provider	Out-of-Network / Non-Participating Provider
Copay	**Exam:** $10 copay **Materials:** $25 copay	**Exam:** Reimbursed up to $50 after $10 copay **Materials:** Reimbursement based on benefit schedule after $25 copay
Frames	$150 allowance after copay	Reimbursed up to $70 copay
Single Vision Lenses	No charge after copay	Reimbursed up to $50 copay
Bifocal Lens	No charge after copay	Reimbursed up to $75 copay
Trifocal Lens	No charge after copay	Reimbursed up to $100 copay
Contacts (Medically Necessary)	No charge after copay	Reimbursed up to $210 copay
Contacts (Elective)	$130 allowance after copay	Reimbursed up to $105 copay
Frequency	**Exam:** Once every calendar year **Lenses**: Once every calendar year **Frames:** Once every other calendar year **Contacts (Elective):** Once every calendar year (in lieu of glasses)	

Computer Vision Care (Family Coverage)	In-Network / Participating Provider	Out-of-Network / Non-Participating Provider
Computer Vision Exam	Evaluates your needs related to computer use	Not Covered
Frames	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance	Not Covered
Lenses	Single vision, lined bifocal, lined trifocal, and occupational lenses	Not Covered

Details about the vision plan

Features	See any provider, but you'll pay more Out-of-Network
What other services are covered?	The plan can also help you save money on LASIK procedures and Computer Vision Care.
Eyeglasses are expensive. I don't think I can afford them, even with vison insurance.	Look for moderately priced frames. Remember that your benefit is higher in-network. If you participate in an HSA or healthcare FSA, you can use tax-free dollars to pay for vision care and eyewear.
Where can I get more details?	Visit www.vsp.com

ENGAGE

Click to play videos

Urgent Care vs ER

Virtual Healthcare

Maximize your healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

KNOW WHERE TO GO

Where you get medical care can significantly influence the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Examples
Nurse line (24/7—No cost) Quick answers from a trained nurse	Identifying if immediate care is needed Home treatment options and advice
Online visit (24/7—$) Many nonemergency health issues	Cold, flu, allergies, headache, migraine Skin conditions, rashes Minor injuries Mental health concerns
Office visit ($$) Routine medical care and management	Preventive care Illnesses, injuries Managing existing conditions
Urgent care ($$$) Non-life-threatening conditions requiring prompt attention	Stitches, sprains Animal bites High fever, respiratory infections
Emergency room (24/7—$$$$) Life-threatening conditions needing immediate care	Suspected heart attack or stroke Major bone breaks Excessive bleeding Severe pain Difficulty breathing

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Virtual Healthcare

Urgent Care vs ER

ALTERNATIVE FACILITIES

If you have time to evaluate your options for nonemergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

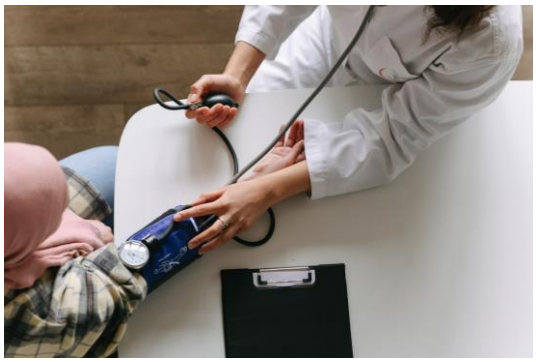
Need	Alternative	Features	Savings
SURGERY	Ambulatory Surgery Center (ASC)	• Specializes in same-day surgeries • Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more • Held to same safety standards as hospitals	Up to 50% over hospital stay*
PHYSICAL THERAPY	Outpatient physical therapy facility	• Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
SLEEP STUDY	Home testing	• Diagnoses sleep apnea and other conditions • Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
INFUSION THERAPY	Home or outpatient infusion therapy	• For drugs that must be delivered by intravenous injections, or epidurals • Delivered by licensed infusion therapy provider • Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay* **in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, and similar services on your plan's website, or call member services for assistance. Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings.

Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PREVENTIVE CARE



You take your car in for maintenance; why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

Health plans are required to cover a set of preventive services at no cost to you, even if you haven't met your deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Be aware: Not all exams and tests are considered preventive care

Certain screenings may be considered diagnostic, rather than preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

In addition, exams performed by specialists are generally not considered preventive care and may not be covered at 100%.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Typical screenings for adults

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

CIGNA PROGRAMS

Fertility Benefits

Cigna plan participants are provided family planning benefits. Services covered include:

- Lab and radiology tests
- Counseling
- Surgical treatment, including:
    - artificial insemination
    - in-vitro fertilization
    - gamete intrafallopian transfer (GIFT)
    - Zygote intrafallopian transfer (ZIFT)

Covered services are limited to a lifetime maximum of $20,000.

Pathwell Bone & Joint Program

Pathwell Bone & Joint is a condition-specific care program that helps members with spine, knee, hip, or shoulder pain find optimal care and lower total medical costs.

Pathwell provides the following for members:

- Guidance to the right care (surgical vs. non-surgical)
- Physical therapy through in person and virtual providers in the Cigna network
- Activities/exercise to improve mobility
- Pain management education
- Healthy lifestyle support

Oncology Consult Service

A comprehensive whole-person health approach supporting members end-to-end through their healthcare journey.

Cigna's Oncology Service brings access to leading expertise in cancer diagnosis and treatment to members wherever they live.

Visana Women's Health

A virtual women's health clinic dedicated to providing care at every stage of life.

Visana offers medical care fore a wide range of women's health conditions.

- Actuarially-driven approach reduces the cost of care
- Comprehensive care, from menstruation to menopause
- World-class OB/GYN team and evidence-based model
- Unparalleled employee experience

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

The formulary drug tiers determine your cost

Generic Drug	$
Brand Name Drug	$$
Specialty Drug	$$$

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to be as effective as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Contact Cigna EAP

Phone: (877) 622-4327
Website: myCigna.com
Employer ID: Infoblox (Needed for initial registration only)

If you're already registered on myCigna.com, simply log in and go to the EAP link under the Review My Coverage tab.

Help for you and your household members

There are times when everyone needs a little help. Cigna EAP can help you handle a wide variety of personal issue such as emotional health and substance use disorder, parenting and childcare needs, financial coaching, legal consultation and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- 6 face-to-face in-person or video counseling sessions for short-term issues
- Unlimited web access to helpful articles, resources, and self-assessment tools.

Counseling benefits
- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

Parenting & childcare
- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

Financial coaching
- Money management
- Debt management
- Identity theft resolution
- Tax issues

Legal consultation
- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Eldercare resources
- Help with finding appropriate resources to care for an elderly or disabled relative

Online resources
- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

LIFE & DISABILITY

Your beneficiary = who gets paid

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. **Make sure that you name at least one beneficiary for your life insurance and AD&D benefits**, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill financial gaps due to a loss of income. Consider your day-to-day costs and bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (housing, education, loans, credit cards, etc.) after the death of a spouse or partner.

If you need more

In addition to company-provided coverage, we offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Plans section for details.

COMPANY-PROVIDED LIFE AND AD&D INSURANCE

A note about taxes

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Basic Life and AD&D

Basic life insurance pays your beneficiary a lump sum if you die. AD&D (accidental death & dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by the company.

The Standard Basic Life and Basic AD&D

2x your basic annual earnings to a maximum of $750,000.

The benefit amount will be reduced if you are age 70 or older. Refer to the plan documents for details.

VOLUNTARY LIFE/AD&D INSURANCE

Protecting those you leave behind

Voluntary life insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

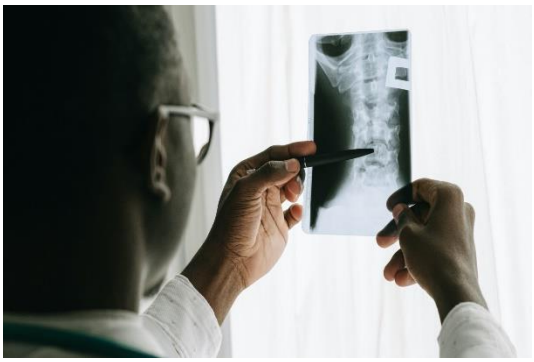
Employee	$10,000 increments up to lesser of 5x Annual Compensation **or** $500,000. Guaranteed issue of $200,000. **Evidence of Insurability may be required if electing more than $200,000 when first eligible or increasing by any amount.*
Spouse	$5,000 increments up to $500,000. Guaranteed issue of $50,000. **Evidence of Insurability may be required if electing more than $50,000 when first eligible or increasing by any amount.*
Child(ren)	$10,000. Guaranteed issue of $10,000.

What's guaranteed issue?

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit **Evidence of Insurability (EOI)** with additional information about your health in order for the insurance company to approve the amount of coverage.

Instructions to submit your EOI are provided after making your benefit elections.

SHORT-TERM DISABILITY (STD) INSURANCE



Expect the unexpected

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

Short-Term Disability (STD) Benefits

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability.

Weekly benefit amount	60% of your weekly earnings up to a maximum of $3,460
Benefits begin	After 7 days of disability due to accident or sickness
Maximum payment period	12 weeks (based on first day you are disabled, not when benefits begin)
Election Required	Pre- or post-tax election required. For details, see Taxation of Disability Benefits.

How STD and LTD Work Together

First 7 Days
PTO replaces 100% of your pay

Next 12 Weeks
Approved STD replaces 60% of your weekly pay

After 90 Days
LTD begins if approved

LONG-TERM DISABILITY (LTD) INSURANCE

Three things to know about long-term disability (LTD) insurance

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

Long-Term Disability (LTD) Benefits

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after Short-Term Disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled.

Monthly benefit amount	60% of earnings up to a maximum of $15,000
Benefits begin	After 90 days of disability
Maximum payment period	Until you recover or reach your Social Security Normal Retirement Age, whichever is sooner
Election Required	Pre- or post-tax election required. For details, see Taxation of Disability Benefits.

How STD and LTD Work Together

First 7 Days
PTO replaces 100% of your pay

Next 12 Weeks
Approved STD replaces 60% of your weekly pay

After 90 Days
LTD begins if approved

TAXATION OF DISABILITY BENEFITS

Who pays for disability insurance premiums (employer, employee, or a combination) and how premiums are paid (pre-tax or after-tax dollars) determine if disability insurance contributions are tax deductible and if benefit payments are taxable or tax-free.

Infoblox's Short-Term and Long-Term Disability coverages, offered through The Standard, provide you with two options for how taxes will be paid should you need to use the benefit:

- You can pay the premium post-tax from your paycheck. If you choose this option, you will receive the benefit tax-free if you become disabled.
- Infoblox pays your premium each payroll however if you become disabled, you will pay tax on the benefits you receive.

Who Pays the Insurance Premium	Is the Benefit Taxable?	How Much of the Benefit is Taxable?
Infoblox pays 100%	Yes	100%
Employee pays 100% with post-tax dollars	No	None

VOLUNTARY BENEFITS

Our voluntary benefits

- Accident Insurance
- Critical Illness Insurance
- LegalEASE
- Wishbone Pet Insurance

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. You can also choose not to sign up for voluntary benefits at all—it's up to you.

ACCIDENT INSURANCE

Eligible Expenses	
	**Emergency Room Visits**
	**Medical Exams –** including major diagnostic exams
	**Fractures and Dislocations**
	**Hospital Stays**
	**Physical Therapy**
	**Transportation and Lodging –** if you are away from home when the accident happens

Sample Reimbursements	
Ground Ambulance	$300
Emergency Room	$150
X-ray	$50
MRI	$150
Hospital Stay – Admission + 5 days	$2,000
Dislocated Hip	$3,000
Appliances	$100
Physical Therapy (4 sessions)	$100
Total Benefit Paid	**$5,850**

Things to consider

Your medical plan helps cover the cost of an accident, but a serious or long-lasting crisis often involves additional expenses and may affect your ability to bring home a full paycheck. This plan provides you with resources to help you get by while there are additional strains on your finances.

Voluntary Accident Insurance, through Cigna, provides a fixed, cash benefit in the event a covered individual sustains injuries or undergoes medical treatments or care resulting from a covered accident. You can find a list of conditions eligible for coverage and the benefit amounts at the link below.

You can use the cash benefit to offset:

- Copays and coinsurance
- Hospitalization
- Emergency room treatment
- Home healthcare costs
- Everyday expenses (e.g., utilities, groceries)

See Cigna Accidental Injury Coverage for more information.

More Information

To learn more or to file a claim, visit Cigna or call **(800) 754-3207**.

How The Plan Works

1. On his way to work, John was in a car accident.
2. He was transported by ground ambulance to the emergency room and admitted to the hospital.
3. He had a dislocated hip and spent five days in the hospital.
4. He had several physical therapy sessions before returning to work.
5. John submitted his accident claim and received $5,850 from his accident insurance coverage.
6. He used it towards his deductible, copay and supplemental income for his missed workdays.

Annual Wellness Benefit

Earn $50 or $75 (depending on your plan) each year for completing wellness treatment, health screening test, or preventive care. Examples includes (but are not limited to) routine gynecological exams, general health exams, mammography, and certain blood tests.

You do not need to submit a claim form or provide any documentation if you are also enrolled in a Cigna medical plan.

CRITICAL ILLNESS INSURANCE

Examples of Covered Conditions
 Heart Attack
 Multiple Sclerosis
 Alzheimer's Disease
 Parkinson's Disease
 Stroke
 Major Organ Failure

Benefit Amount	
Employee	$5,000, $10,000 or $20,000
Spouse	50% of employee amount
Children	25% of employee amount

Things to consider

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. This plan provides you with resources to help you get by while there are additional strains on your finances.

Critical Illness Insurance through Cigna pays a lump-sum benefit if you are diagnosed with a covered illness or condition on or after your coverage date, giving you and your family flexibility to pay bills related to treatment or to help with everyday living expenses. Importantly, the benefit allows you to focus on recovering instead of out-of-pocket medical costs and personal bills.

See a list of covered conditions and benefit amounts at the link below.

Cigna Critical Illness Coverage

More Information

Please note that new enrollees for Critical Illness Insurance have a pre-existing condition limitation of six months.

To learn more or to file a claim, visit Cigna or call **(800) 754-3207**.

How The Plan Works

1. Tom suffered a relatively small stroke
2. He was hospitalized for five days.
3. He began rehab to get back to where he was physically before the stroke.
4. Tom submitted his claim and received a lump-sum payment of $10,000.

Annual Wellness Benefit

Earn $50 each year for completing wellness treatment, health screening test, or preventive care. Examples includes (but are not limited to) routine gynecological exams, general health exams, mammography, and certain blood tests.

You do not need to submit a claim form or provide any documentation if you are also enrolled in a Cigna medical plan.

LegalEASE

Plan Details:

$17.96 Monthly via payroll deduction

Who's Covered:

Employee, Spouse, Dependent Children up to age 26, Parents – Elder benefits designed for Plan member's and spouse's parents

With LegalEASE , you're covered when you run into life's challenges with paid in full benefits for personal legal matters.

LegalEASE has the largest and most highly qualified Attorney Provider Network, with attorneys in all 50 states focusing in over 60 areas of law.

We've got you covered no matter your situation or location.

You can change enrollment **only** at open enrollment, as a new hire or with a qualifying event

What's Included?

- FAMILY LAW
- ESTATE PLANNING & WILLS
- AUTO & TRAFFIC
- HOME & RESIDENTIAL
- FINANCIAL & CONSUMER
- GENERAL COVERAGE

Enroll Today!
Website: www.legaleaseplan.com/infoblox
Phone: (800) 248-9000

PET INSURANCE

Be prepared in case your pet gets sick or injured with Wishbone pet insurance.

Wishbone is accepted at any vet in the U.S., including emergency hospitals. They offer a simple online claims process that means you get your money back fast, whether it's for routine care or an accident.

Protecting your pet's health and your finances has never been easier!

Available Wishbone Plans

Wishbone offers different plan options to fit your budget.

Accident & Illness Plan
For the unexpected

- 80% reimbursement
- $250 deductible
- $10,000 annual limit
- Includes 24/7 pet telehealth

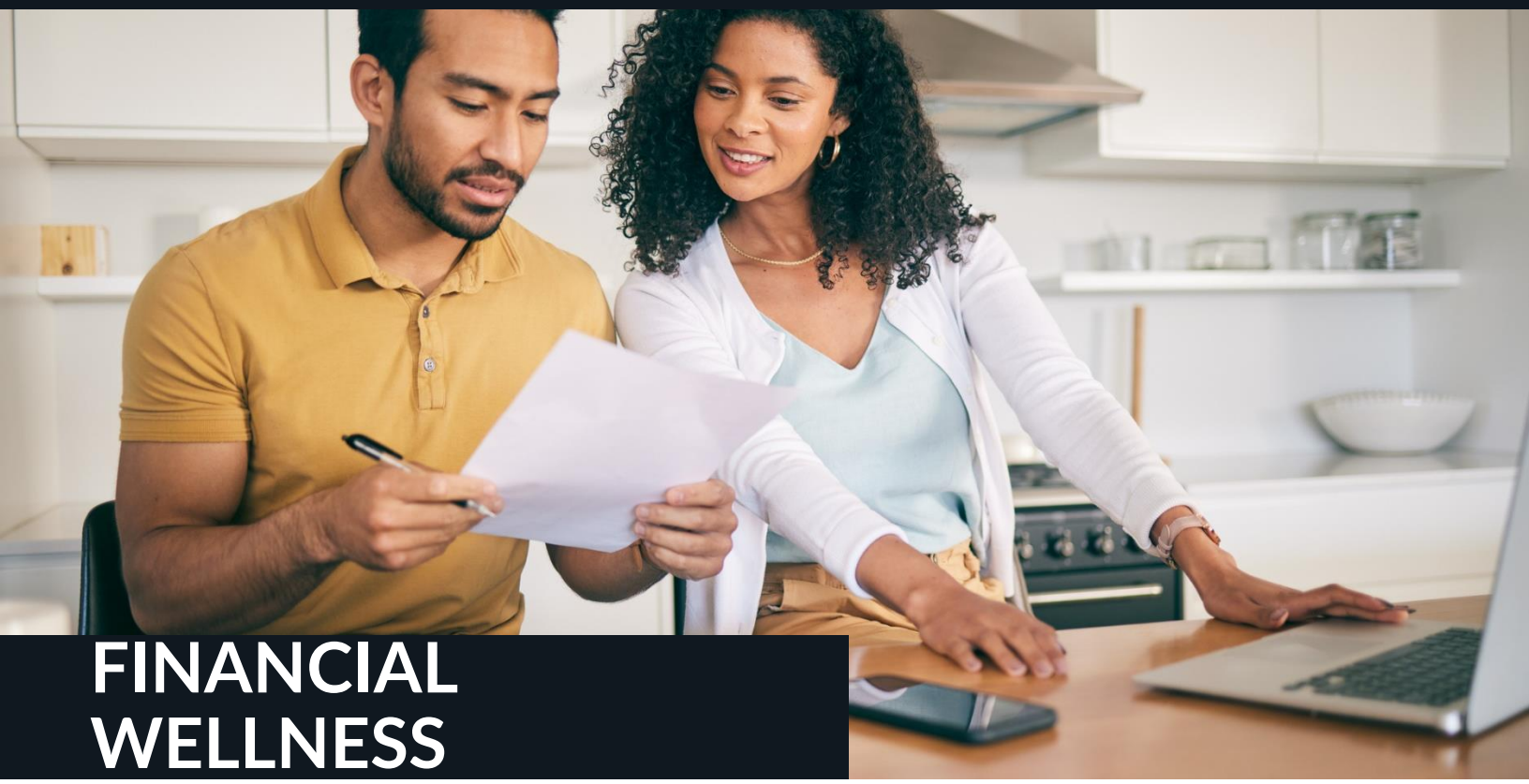
Rates based on your pet's age, breed & zip code.

Wellness Plan
For regular routine visits

Essential Plan	Premium Plan
Up to $300 in coverage	Up to $575 in coverage
$14/month	$25/month

Reimbursements are based on a schedule of benefits outlined during enrollment.

Enroll Today!
Website:
www.wishboneinsurance.com/infoblox
Phone: (800) 887-5708



FINANCIAL WELLNESS

Plans to help you save

- 401(k) Retirement Savings Plan
- Dependent Care Flexible Spending Account
- Commuter Benefits
- Travel Insurance
- Healthcare Flexible Spending Account

Is it time for a "financial wellness" checkup?

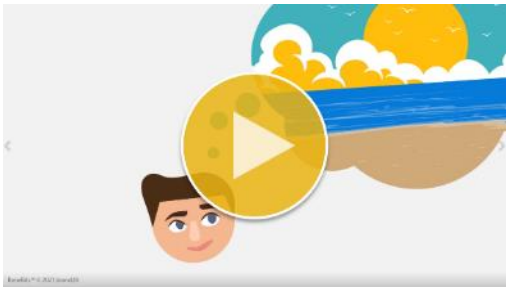
Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? What about retirement?

Ignoring your financial health can take a toll on your quality of life today and in the future. And worrying about money can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money. You can reduce your tax burden, work toward your retirement.

401(k) RETIREMENT SAVINGS PLAN

Click to play video



What are your plans?

Our 401(k) retirement plan will help you set a retirement savings goal and stick to it.

The important thing is to start now and set aside what you can, even if it's a small amount.

With Infoblox's match and compound interest, that "small amount" can grow over time.

You'll be a retirement saver before you know it.

Save now, enjoy later

Our 401(k) Retirement Savings Plan helps you save for retirement with pre-tax contributions, a post-tax 401(k) Roth, and if you've reached the maximum in those plans, there's an additional After-tax plan to consider.

Visit the Vanguard website or call **(800) 523-1188** to manage your account, investments and contributions.

Plan # – 097457

Vanguard offers a variety of quality investment options..

Maximum annual contribution limit	Up to $23,500* per year. If you're age 50+ save an additional $7,500* or more. Check out the Super Catchup option on the Benefits Portal. Contributions can be made pre-tax or Roth after-tax.
Infoblox matching contributions	100% of every $1.00 you contribute, up to 3% of eligible earnings. Infoblox can only match pre-tax and post-tax Roth contributions. To receive your employer-match, you must Actively Enroll in your 401(k).
Vesting	Vesting refers to your ownership of the money in your account, and at Infoblox, you are always 100% vested.

*IRS limits are evaluated annually and may change. Contributions can be made pre-tax or Roth after-tax.

Important differences of a Roth 401(k)

- You pay taxes when you contribute, at your current tax rate.
- Account interest and dividends are not taxed if you meet certain criteria.
- Like a traditional 401(k), you can withdraw money without penalties when you reach age 59½, but you must have held the account for at least 5 years.
- You are not forced to take distributions at age 70½. You can keep the money in your Roth account as long as you want.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

Every opportunity to save

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Paying for daycare? Make it tax-free! Up to $5,000 per year tax-free

A Dependent Care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by WEX Health.

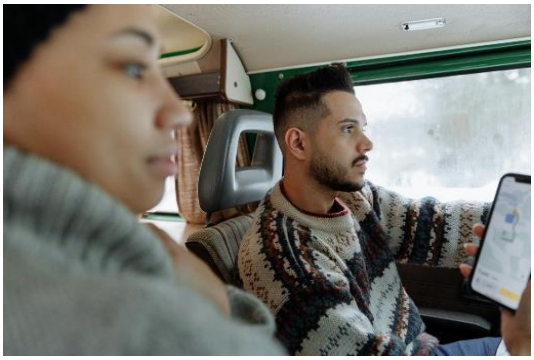
Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children younger than 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a Dependent Care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

COMMUTER BENEFITS



Contact Wex Health
Phone: (866) 451-3399
Website:
benefitslogin.wexhealth.com

Commuter Spending Account—up to $325 per month tax-free

If you have out-of-pocket commuting expenses for public transportation, vanpooling, or worksite parking, you can save on taxes when paying for the expenses by enrolling in commuter benefits. The Commuter Spending Account lets you set aside pre-tax money through payroll deductions to help you pay expenses related to commuting to and from work.

Your contribution is deducted from your paycheck on a pretax basis and is put into your Commuter Spending Account. You can access the funds in your account to pay for eligible commuting-related expenses.

Eligible Expenses

Expenses for commuting to and from work, or paying parking fees at your work location, including:

- Transportation to or from work on a subway, train, bus, ferry, etc.
- Parking at or near your workplace or at a commuter lot where you transfer to a vanpool or mass transit.

Contributions

The maximum contribution is $325 per month to your transit/vanpool account and $325 per month to your parking account.

- You can start or stop your monthly contributions at any time during the year.
- Unused funds roll over into the next month.
- Funds also roll over from year to year.
- If you leave the company and have funds in your account, you will forfeit the unused money in your account.

TRAVEL INSURANCE

Starter Kit PDF

Save the Chubb Travel Assistance Program Start Kit and add to your file on iOS or Android devices.

Global Business Travel Accident Insurance

Chubb's Business Travel Accident coverage provides you with 24/7 assistance services worldwide including travel, medical, and security. This coverage includes:

- Coverage for accidental death and dismemberment
- Emergency medical referrals
- Emergency travel assistance
- Security evacuation assistance

Before your trip, visit the Benefits Portal to print an ID card to take with you.

Call for information:

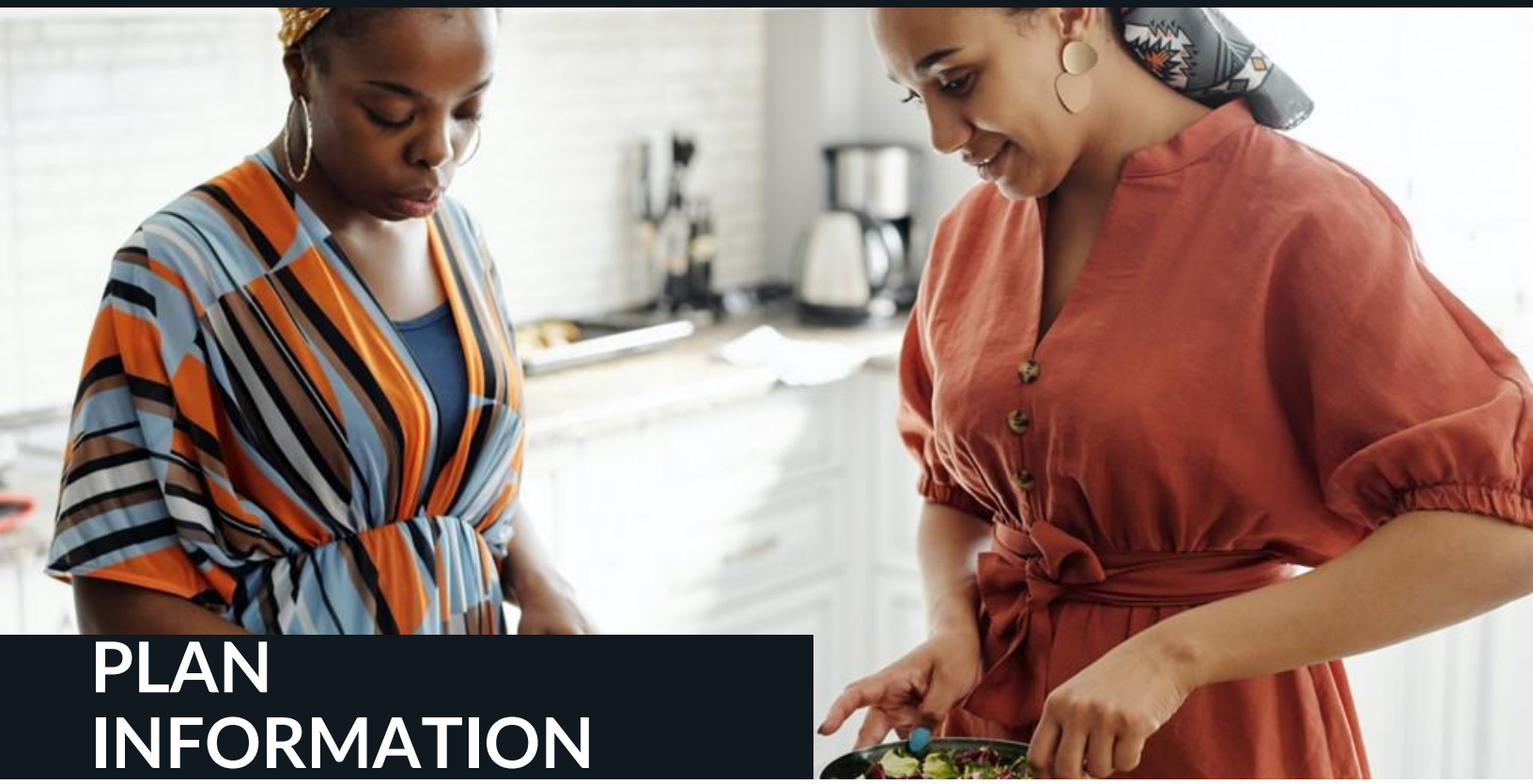
- Inside the U.S. or Canada: **(855) 327-1414**
- Outside the U.S.: **(630) 694-9764** (Call Collect)
- Email at: MedAssist-USA@AXA-Assistance.us

Global Business Travel Medical Insurance

With Medical Benefits Abroad insurance through Cigna, you and your covered dependents have extra protection while traveling for business, as well as personal of up to 14 days beyond the business trip. This coverage includes medical evacuation, medical repatriation, crisis assistance, and cash benefits for accidental death and dismemberment.

Before your trip, visit the Benefits Portal to print an ID card to take with you.

Assistance is available 24 hours a day, 7 days a week at **(302) 797-3535.**



PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit costs for 2025
- Contact information for our benefit carriers and vendors
- A Benefits Glossary to help you understand important insurance terms
- A summary of the health plan notices you are entitled to receive annually, and where to find them

YOUR MONTHLY BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis—before federal, state, and social security taxes are calculated—so you pay less in taxes.

Medical

	CIGNA OAP HDHP		CIGNA OAP PPO	
Coverage Tier	**Infoblox Cost**	**Your Cost**	**Infoblox Cost**	**Your Cost**
Employee Only	$710.53	$87.00	$905.40	$232.00
Employee + Spouse/DP	$1,511.20	$256.00	$1,894.21	$623.00
Employee + Child(ren)	$1,225.98	$218.00	$1,547.29	$510.00
Family	$2,153.44	$341.00	$2,669.05	$883.00
	KAISER HDHP		**KAISER HMO**	
Coverage Tier	**Infoblox Cost**	**Your Cost**	**Infoblox Cost**	**Your Cost**
Employee Only	$566.31	$87.00	$633.04	$232.00
Employee + Spouse/DP	$1,181.29	$256.00	$1,280.10	$623.00
Employee + Child(ren)	$1,088.62	$218.00	$1,220.09	$510.00
Family	$1,618.94	$341.00	$1,712.14	$883.00

Dental & vision

	CIGNA DENTAL PPO		VSP VISION	
Coverage Tier	**Infoblox Cost**	**Your Cost**	**Infoblox Cost**	**Your Cost**
Employee Only	$36.83	$19.00	$5.89	$2.00
Employee + Spouse/DP	$73.88	$38.00	$10.51	$3.00
Employee + Child(ren)	$91.62	$48.00	$10.80	$3.00
Family	$128.68	$67.00	$17.22	$5.00

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Infoblox if your domestic partner is your tax dependent.

PLAN CONTACTS

Coverage Type	Insurance Carrier / Plan Vendor	Phone Number	Website	Policy/Group #
Medical & Prescription Drug	Cigna	(800) 244-6224 **Pre-enrollment:** (888) 806-5042	mycigna.com	Infoblox Inc.: 3335382 Infoblox Federal Inc.: 2499245
	Kaiser	(800) 464-4000	kp.org	600773
Health Savings Account	HSA Bank	(800) 244-6224	Cigna: mycigna.com Kaiser: choicefund.hsabank.com	
Dental	Cigna	(800) 244-6224	mycigna.com	Infoblox Inc.: 3335382 Infoblox Federal Inc.: 2499245
Vision	VSP	(800) 877-7195	vsp.com	12251437
Life Insurance and Disability	The Standard	(800) 628-8600	standard.com	761411 – Basic Life and AD&D, Vol. Life and AD&D, Long-Term Disability 761413 – Short-Term Disability
Flexible Spending Accounts, Commuter Benefits	WEX	(866) 451-3399	wexinc.com	28726
401(k)	Vanguard	(800) 523-1188	vanguard.com/retirement	097457
Accident & Critical Illness	Cigna	(800) 754-3207	cigna.com	Accident: 960841 Critical Illness: 960811
Employee Assistance Program	Cigna	(877) 622-4327	mycigna.com	Login: infoblox
Travel Assistance	Chubb	Inside US: (855) 327-1414 Outside US: (630) 694-9764 (Call Collect)	TravelAssistance.Chubb.com	9912-41-89
Global Business Travel Medical	Cigna	Inside US: 800.243.1348 Outside US: 302.797.3535	customer.cignaenvoy.com/traveler	Username: 09000AMBA Password: Cigna1
Legal	LegalEASE	(800) 248-9000	www.legaleaseplan.com/infoblox	
Pet Insurance	Wishbone	(800) 887-5708	www.wishboneinsurance.com/infoblox	

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Note: Beginning January 1, 2022 the "No Surprises Act" provides protections against surprise billing for emergency services, air ambulance services, and certain services provided by a non-participating provider at a participating facility. For these services, the member's cost are generally limited to what the charge would have been if received in-network, leaving any balance to be settled between the insurer and the out-of-network provider. Consult your health plan documents for details.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive
Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA)
An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

GLOSSARY

High Deductible Health Plan (HDHP)
A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of-network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non- preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

Health plan notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on our benefits website:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

Cobra continuation coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

Deadline for filing lawsuit under ERISA after exhaustion of all claims procedures

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available on our benefits website . Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

Summary plan descriptions (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- The Infoblox Health and Welfare Plan Summary Plan Description

Summary of benefits and coverage (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available on the benefits website.

- Cigna OAP PPO (All U.S.)
- Cigna OAP HDHP (All U.S.)
- Kaiser HMO (California Only)
- Kaiser HDHP (California Only)

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact benefits@infoblox.com.

Statement of material modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Infoblox Health and Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

DETERMINING ELIGIBILITY

Employee eligibility: look-back measurement method

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee whose works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Infoblox uses the look-back measurement method to determine group health plan eligibility.

NEW EMPLOYEES HIRED TO WORK FULL-TIME: If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of 12-month.

NEW EMPLOYEES HIRED TO WORK A PART-TIME, VARIABLE HOUR OR SEASONAL SCHEDULE: If you are hired into a part-time position, a position where your hours vary and Infoblox is unable to determine—as of your date of hire—whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months. Your IMP will begin on your date of hire. If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage by the first of the month after your IMP ends. Your full-time status will remain in effect during an associated stability period that will last 12 months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

ONGOING EMPLOYEES: An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period during which Infoblox counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for 12 months. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Infoblox uses the standard measurement period and associated stability period annual cycle set forth below:

MEASUREMENT PERIOD: November 1 through October 30. Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility.

STABILITY PERIOD: January 1 through December 31. Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.

This brochure highlights the main features of the Infoblox Employee Benefits Program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Infoblox reserves the right to change or discontinue its employee benefits plans at any time

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