OKTA, INC.

INFERTILITY HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN

EFFECTIVE JANUARY 1, 2021

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ARTICLE I

ESTABLISHMENT AND PURPOSE OF THE PLAN

1.01 Establishment of Plan. Effective as of January 1, 2021, Okta, Inc. (the "Company") hereby establishes this Infertility Health Reimbursement Arrangement ("HRA") Plan (hereinafter "Plan"). This Plan is integrated with the Okta, Inc. Welfare Benefits Plan and shall be administered accordingly.

1.02 Purpose.

a. Tax Treatment

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Internal Revenue Code ("Code") Sections 105 and 106 and regulations issued thereunder, and as a "health reimbursement arrangement" or "HRA" as defined under IRS Notice 2002-45. The Plan will be interpreted at all times to accomplish that objective. Amounts reimbursed under the Plan are intended to be eligible for exclusion from Plan participants' gross income under Code Section 105(b).

b. ERISA Group Health Plan

This Plan document is intended to serve as a written instrument for the Plan as required under Employee Retirement Income Security Act of 1974 ("ERISA") Section 402(a)(1).

ARTICLE II

DEFINITIONS

Any capitalized term used but not defined in the Plan shall have the meaning defined in the Agreement. When used in this Plan, the following words and phrases shall have the following meanings:

2.01 **Claims Administrator**. The entity designated by the Employer to administer claims under Section 5.03 of this Plan.

2.02 **Claimant.** An individual who makes a claim for reimbursement in accordance with Section 5.03 of this Plan.

2.03 **COBRA.** The Consolidated Omnibus Budget Reconciliation Act of 1985, and Treasury Regulations and guidance issued thereunder, as amended.

2.04 **Code**. The Internal Revenue Code of 1986, as amended.

2.05 **Compensation**. The wages or salary paid to an Employee by the Employer.

2.06 **Covered Expense**. Generally means a medical expense incurred in accordance with the Plan by an Participant or Qualified Beneficiary, or their spouse or domestic partner, for fertility-related care for the purpose of overcoming an inability to have children to the extent such expenses qualify as medical care, as defined in Code §213(d) and is included in the list of Covered Expenses in Exhibit A.

2.07 **Effective Date**. January 1, 2021.

2.08 **Eligible Employee.** An individual is an Eligible Employee and may become a Participant in this Plan if the individual (a) is an Employee; (b) regularly works 30 hours or more per week, subject to any applicable foreign legal requirements; and (c) has been employed by the Employer for 30 consecutive calendar days, counting his or her Employment Commencement Date as the first such day. In addition, an Employee who is not regularly working 30 hours or more per week, but who qualifies as a "full-time" employee under the Affordable Care Act's employer shared responsibility provisions, shall also be an Eligible Employee if the other conditions in the preceding sentence are satisfied. An Employee who becomes an Eligible Employee and who has submitted an Enrollment Form to the Administrator shall be enrolled in the Plan and become a Participant as described in Article III.

2.09 **Employee**. An individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code §414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is

determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation, including those deemed to be a more-than-2% shareholder by virtue of the Code §318 ownership attribution rules. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits in accordance with Section 3.03 and 5.08.

2.10 **Employer.** Okta, Inc., a Delaware corporation.

2.11 **Employment Commencement Date**. The first regularly scheduled working day on which an Employee first performs an hour of service for the Employer for Compensation.

2.12 **ERISA**. The Employee Retirement Income Security Act of 1974, as amended.

2.13 **FMLA**. The Family and Medical Leave Act of 1993, as amended.

2.14 **HDHC Plan**. The high deductible health care plans identified on Exhibit B, attached hereto.

2.15 **Highly Compensated Individual**. An individual defined under Code §105(h), as amended, as a "highly compensated individual.".

2.16 **HIPAA.** The Health Insurance Portability and Accountability Act of 1996, as amended.

2.17 **HRA.** A health reimbursement arrangement as defined in IRS Notice 2002-45, and related IRS guidance.

2.18 **Participant.** An Eligible Employee who has met the eligibility requirements under Section 3.01 and commenced participation in the Plan under Section 3.02. A Qualified Beneficiary shall also be treated as a Participant for purposes of payment of benefits under Article V.

2.19 **Period of Coverage.** The Period of Coverage shall be the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31).

2.20 **Plan.** This Okta, Inc. Infertility Health Reimbursement Arrangement (HRA) Plan, as set forth herein, and any modification, amendment, extension or renewal thereof.

2.21 **Plan Administrator**. Okta, Inc. or "Okta", notwithstanding that certain administrative functions for the Plan may be delegated to another entity or individual.

2.22 **Plan Sponsor**. The Employer.

2.23 **Qualified Beneficiary**. Qualified Beneficiary means a Participant in the Plan, or a Participant's spouse or domestic partner who was covered under this Plan on the day before a qualifying event that provides such individual an opportunity to continue Plan coverage under COBRA, provided such individual (a) elects COBRA coverage under the Plan and timely pays the applicable COBRA premium, and (b) elects COBRA coverage under a group health plan sponsored by the Employer that meets the requirements of

Treasury Regulation §54.9815-2711(d)(2)(ii) and timely pays the applicable COBRA premium for such coverage.

2.24 **USERRA**. The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III

ELIGIBILITY AND PARTICIPATION

3.01 **Eligibility for Participation.** Only an Eligible Employee or a Qualified Beneficiary, as defined in Article II, may participate in the Plan. Any person who does not meet the definition of an Eligible Employee or a Qualified Beneficiary will not be entitled to any benefits under the Plan.

3.02 **Commencement of Participation.** For Periods of Coverage beginning on and after the Effective Date, an Eligible Employee will become a Participant in the Plan as of the first date on which the Eligible Employee submits a request for reimbursement for Covered Expenses.

3.03 **Termination of Participation.** Except for continuation coverage as may be provided under section 5.08 of the Plan, coverage under the Plan will terminate upon the earlier of:

a. The effective date of termination of the Plan;

b. The date on which a Participant ceases to be an Eligible Employee; or

c. The date on which a Participant has received reimbursements for Covered Expenses that, together with amounts reimbursed to the Participant for adoption, surrogacy, or other benefits provided pursuant to those plans, programs, and agreements described on Exhibit C attached hereto.

If the Plan terminates, the Employee loses HDHC Plan coverage, or exhausts his or her HRA Account balance, the Employee's loss of Participant status shall occur immediately upon occurrence of the applicable event. If an Employee ceases to be a Participant for any other reason, the Employee's loss of Participant status shall occur at the end of the month in which the applicable event occurs. Any reimbursements from the HRA Account after termination of participation will be made pursuant to Section 5.08 (relating to the run-out period for submitting claims incurred prior to termination and relating to COBRA).

3.04 **Participation Following Termination of Employment or Loss of Eligibility.** If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days of the date of the termination of employment, the rehired Employee will be reinstated with the same HRA Account balance that such individual forfeited at termination, provided the individual is enrolled in the HDHC Plan and meets the other requirements to be an Eligible Employee (disregarding the break in employment). If an Employee (whether or not a Participant) terminates employment and is not rehired within 30 days or ceases to be an Eligible Employee for any other reason for more than 30 days (including, but not limited to, a reduction in hours or loss of HDHC Plan coverage), the Employee's service before his or her loss of Eligible Employee status will not be taken into account when determining whether the Employee has regained Eligible Employee status, so the Employee will be required to complete any applicable waiting period described in this Plan before again becoming eligible to participate in the Plan.

3.05 **FMLA and USERRA Leaves of Absence**. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee.

3.06 **Non-FMLA and Non-USERRA Leaves of Absence**. If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation, as described above under Section 3.03.

ARTICLE IV

FUNDING

4.01 **Participant Contributions.** Participant contributions to the Plan are not permitted except as provided in section 5.08 in relation to COBRA coverage.

4.02 **Employer Funding**. All benefits under the Plan will be paid by Employer.

4.03 **No Funding under Cafeteria Plan.** Under no circumstances will benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan.

4.04 **Funding of the Plan.** All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no requirement for a trust to be established under the Plan.

ARTICLE V

BENEFITS

5.01 Benefits Eligibility.

a. Except as provided in Section 5.01(b), a Participant shall be eligible to receive reimbursement of Covered Expenses incurred on and after the Effective Date until the Participant's participation in the Plan terminates under Section 3.03.

b. For each Period of Coverage, a Participant who is enrolled in a HDHC Plan with a health savings account within the meaning of Code section 223(d) shall be eligible to receive reimbursement of Covered Expenses incurred on and after the date the Participant has incurred medical expenses within the definition of Code section 213(d) in excess of the applicable IRS minimum deductible under Code section 223(c)(2), as adjusted annually; provided, however, that for purposes of determining whether such minimum deductible has been satisfied, only those expenses that also qualify as expenses under, and are covered by, the HDHC Plan shall be taken into account..

c. A Qualified Beneficiary shall be eligible to receive reimbursement of Covered Expenses as provided under COBRA.

5.02 Benefits Limit. The Plan will reimburse Covered Expenses for any Period of Coverage up to the maximum benefit amount described below. No other benefit is provided under the Plan.

a. Maximum Benefit. The maximum benefit payable under this Plan is $5,000, which shall be reduced by the amount reimbursed to the Participant for adoption, surrogacy, or other benefits provided pursuant to those plans, programs, and agreements described on Exhibit C attached hereto.

b. Period of Coverage. Only expenses incurred by a Participant during a Period of Coverage will be eligible for reimbursement.

c. Changes. The Maximum Benefit for future Periods of Coverage may be changed by the Employer and shall be communicated to employees.

d. Nondiscrimination. Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation by the Employer to comply with Code §105(h).

5.03 Claims for Reimbursement. As of the Effective Date, the Plan Administrator has designated Carrot Fertility, Inc. as the Claims Administrator and delegated to the Claims Administrator responsibility for the adjudication and processing of Participant reimbursement claims.

a. Eligible Expenses. To receive a reimbursement under the Plan, a Participant or Qualified Beneficiary must incur an expense that qualifies for reimbursement, i.e. a Covered Expense.

b. Manner of Claim. A claim for reimbursement shall be made by the Participant or Qualified Beneficiary, or his or her authorized representative ("Claimant"), by uploading a paid statement or superbill from a qualifying provider approved by the Claims Administrator via the Claims Administrator's platform, or by such other method determined, from time to time, by the Claims Administrator.

c. Time Period for Filing Claims**.** Participants shall have until March 31st following the end of each Period of Coverage to submit requests for reimbursement of eligible Covered Expenses incurred in the previous Period of Coverage.

d. Claims Substantiation. In addition to the requirements set forth in the Agreement, a claim must set forth:

1. the name of the individual(s) for whom a Covered Expense was incurred;

2. the nature and date of the Covered Expense incurred;

3. the amount of the requested reimbursement; and

4. a statement that such Covered Expense has not otherwise been reimbursed and is not reimbursable through any other source and that Claimant will not request reimbursement from any other source.

e. Denied Claims. Sections 5.04, 5.05 and 5.06, below, apply to denied claims.

f. Reimbursements After Termination. No Covered Expense incurred after participation in the Plan terminates shall be reimbursed. A Participant (or the Participant's estate) may submit a claim for reimbursement of any Covered Expense incurred during the Period of Coverage immediately prior to termination of participation, by March 31st following the end of each Period of Coverage after the Covered Expense was incurred.

5.04 Claims Review and Payment of Benefits.

a. Timing of Claims Review.

1. Within thirty (30) days after receipt by the Claims Administrator of a claim for reimbursement of any Covered Expense, the Claims Administrator will notify the Claimant of its determination of the claim. The 30-day time period may be extended for an additional fifteen (15) days for matters beyond the control of the Claims Administrator, including in cases where a claim is incomplete. The Claims Administrator will provide written notice of any extension, including the reasons for the extension.

2. If the claim does not include substantially all of the information required, or otherwise fails to follow the Plan's procedures for filing claims, the Claims Administrator shall notify the Claimant (or the Claimant's authorized representative) within thirty (30) days of the informational or procedural deficiency and how it may be cured. The Claimant shall be given forty-five (45) days to provide the necessary information.

b. Payment of Benefits. Reimbursement of approved claims will be paid by automated clearing house ("ACH") payment pursuant to the claims processing schedule agreed to by the Employer and the Claims Administrator.

5.05 Notice of Denied Claims. Any denial of a claim shall be provided in writing and shall include:

a. The specific reason(s) for the denial;

b. References to the Plan provisions on which the denial was based;

c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

d. The Plan's appeal procedures and the time limits applicable to such procedures;

e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; and

f. If the denial is based on experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's circumstances, or a statement that such explanation will be provided free of charge upon request.

5.06 Appeal Procedures.

a. Named Fiduciary. The Claims Administrator is the "appropriate named fiduciary" under Department of Labor Regulation 2560.503-1(h)(1). As the Plan's named fiduciary for claims and appeals, Claims Administrator has discretionary authority to determine all claims and appeals. The Claims Administrator's determinations shall be final, binding, and conclusive on all persons.

b. Timing of Filing an Appeal. A Claimant whose claim is denied, in whole or in part, must file a written request for review (appeal) with the Claims Administrator within one hundred eighty (180) days after the receipt of written notice of such denial from the Claims Administrator. If a request for review is not made within the above-referenced timeframe, all rights to an appeal and to file suit in court will be permanently forfeited.

c. Review by Claims Administrator. The following procedures shall apply to the review of the appeal:

1. The Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim;

2. The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (other than privileged documents);

3. The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such comments, documents, records, and other information were submitted or considered in the initial benefit determination;

4. The review shall not afford deference to the initial claim denial and shall be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual;

5. In deciding an appeal that is based in whole or in part on a medical judgment, the Claims Administrator shall consult with an independent health care professional that is qualified in the areas of dispute and was not involved in the initial claim denial; and

6. The Claims Administrator shall, upon request, provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

d. Timing of Notice of Decision on Appeal. If a Claimant appeals, the Claims Administrator shall transmit its written decision of the appeal to the Claimant within sixty (60) days of its receipt of the request for review. If special circumstances require an extension of time, written notice of the extension shall be given to the Claimant before the end of the original 60-day period, and a decision shall be rendered as soon as possible, but not later than one hundred twenty (120) days after receipt of the request for review.

e. Notice of Denial of Appeal. A notice of an adverse determination on review (denied appeal) shall set forth, in a manner calculated to be understood by the Claimant (or the Claimant's authorized representative):

1. The specific reason(s) for the adverse determination;

2. Reference to the Plan provisions on which the adverse determination is based;

3. A statement that the Claimant (or the Claimant's authorized representative) is entitled to receive without charge reasonable access to any document (a) relied on in making the determination, (b) submitted, considered or generated in the course of making the benefit determination, (c) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (d) constitutes a statement of policy or guidance with respect to the Plan

concerning the denied appeal without regard to whether the statement was relied on;

4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;

5. If the adverse determination is based on experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's circumstances, or a statement that this will be provided without charge on request; and

6. A statement describing the Claimant's right to bring a civil action under ERISA §502(a), including notice of the Plan's limitations period for bringing a civil action.

f. Limitations Period. Notwithstanding any other provision of the Plan, a civil action related to a claim for benefits must be filed within one year from the date on which the Claims Administrator provides notice that the Claimant's appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

5.07 Compliance with Applicable State and Federal Laws. Benefits under the Plan shall be provided in compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and other applicable group health plan laws, as such are amended and to the extent required by such laws.

5.08 COBRA. An Eligible Employee who participates in this Plan, and any spouse or domestic partner of an Eligible Employee who participates in this Plan, who is a "qualified beneficiary" within the meaning of COBRA, and whose coverage terminates under the Plan because of a "qualifying event" within the meaning of COBRA, shall be given the opportunity to continue the Plan coverage that he or she had on the day before the qualifying event for the periods prescribed by COBRA, only if the Qualified Beneficiary elects COBRA, subject to all conditions and limitations under COBRA. However, in the event that such coverage is modified for all similarly-situated non-COBRA Participants prior to the date continuation coverage is elected, such a Qualified Beneficiary shall be eligible to continue the same coverage that is provided to similarly-situated non-COBRA Participants. A premium for continuation coverage shall be charged to the Qualified Beneficiary in such amounts and shall be payable at such times as are established by the Plan Administrator and permitted by COBRA. The Plan Administrator shall determine the COBRA premium annually. The twelve-month determination period begins each January 1 (the calendar year).

ARTICLE VI

PLAN ADMINISTRATION

6.01 Plan Administration. The Employer is the Plan Administrator and may delegate any duty or power to another entity or individual. The Plan shall be administered for the exclusive benefit of persons entitled to participate in the Plan.

6.02 Duties of Plan Administrator. Unless delegated to another person or entity, the Plan Administrator has the duty and full power to administer this Plan.

a. General Powers and Duties. Except as delegated to the Claims Administrator, the Plan Administrator shall have full and sole discretionary authority to determine all questions concerning the administration, interpretation, and application of the Plan, including full and sole discretionary authority to determine eligibility for benefits and to construe the terms of the Plan. Any such determination by the Plan Administrator made in exercise of its discretionary authority shall be conclusive and binding upon all persons. The discretionary power of the Plan Administrator shall be exercised in a non-discriminatory manner with regard to all similarly situated Eligible Employees or Participants. The Plan Administrator shall be deemed to have properly exercised its authority unless it has abused its discretion hereunder by acting arbitrarily or capriciously.

b. Specific Duties. The powers and duties of the Plan Administrator include, but are not limited to, the following:

1. To adopt such procedures and regulations as are necessary for the proper and efficient administration of the Plan and consistent with the terms and purposes of the Plan;

2. To request and receive from all Eligible Employees such information as the Plan Administrator will from time to time determine to be necessary for the proper administration of the Plan;

3. To maintain all necessary records for the administration of the Plan; and

4. To comply with any applicable statutory or regulatory requirement under local, state or federal law to disclose or report information about the Plan, Participants, Eligible Employees, or the Employer, and to disclose such information subject to any legal enforcement activity or subpoena.

c. Claims Administration. As of the Effective Date, the Plan Administrator has delegated to the Claims Administrator responsibility for the adjudication and processing of Participant claims and appeals, limited to the power and duty to:

1. make any determination as to what constitutes a Covered Expense;

2. authorize the payments of benefits;

3. prescribe procedures to be followed and the forms to be used to claim reimbursements pursuant to this Plan; and

4. review claims or claim denials under the Plan.

d. Payment of Expenses of Administering the Plan. All reasonable expenses incurred in administering the Plan are paid by the Employer.

6.03 Bonding. The Plan Administrator shall be bonded to the extent required by ERISA.

6.04 Corrections.

a. General Rule. Amounts paid in error belong to the Plan. The Plan Administrator may require an increase or decrease in any benefits or may collect previously paid benefits if, after payment has commenced, any error in any pertinent information or any mistake in payment is discovered.

b. Lien. The Plan possesses a lien on any amounts paid but not owed under the terms of the Plan in the amount of the overpayment plus interest. The lien is enforceable regardless of the reason for the mistake in payment or the fault or knowledge of the person in possession of the mistakenly paid amount. Any person in receipt of an amount paid but not owed under the Plan has an obligation to immediately notify the Plan Administrator of the overpayment and to promptly return the overpaid amount to the Plan. The lien shall remain in effect until the Plan is repaid in full.

c. Corrective Action. The Plan Administrator may, on behalf of the Plan, take whatever action is necessary to enforce the Plan's lien on any overpayments. The Plan Administrator has sole discretion to choose the methods for enforcing the Plan's lien. These methods include, without limitation, the Plan's recoupment of the overpayment from future benefit payments and a court action seeking imposition of a constructive trust and disgorgement of the overpaid amount plus interest, or any other claim under applicable law.

d. Mistake of Fact. Any mistake of fact or misstatement of fact, other than benefits paid in error, shall be corrected when it becomes known and proper adjustment shall be made. The Employer and Claims Administrator shall not be liable in any manner for any determination of fact made in good faith.

6.05 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such person will be forfeited following a reasonable time after the date any such payment first became due.

6.06 Appointment of Advisors. The Plan Administrator may engage the service of advisers, professionals and other persons to help it carry out its responsibilities.

6.07 Allocation of Responsibility. Except to the extent required by law, no party acting (or declining to act) shall have any liability for a breach of duty of another party with respect to the Plan.

ARTICLE VII

PROTECTED HEALTH INFORMATION

7.01 Definitions.

Whenever used in this Article, the following terms shall have the respective meanings set forth below. All capitalized terms used but not otherwise defined in this Article VII shall have the same meaning as those terms have under HIPAA and the HITECH Act, including the regulations implementing the privacy and security rules of HIPAA and the HITECH Act.

a. "Health Information" means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 CFR § 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined in 45 CFR § 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

b. "Protected Health Information" ("PHI") means Health Information, including demographic information, that is (1) transmitted or maintained in any form or medium, (2) collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse, and (3) identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved. PHI includes electronic PHI ("ePHI") described in 45 CFR §160.103.

c. "Summary Health Information" means Health Information that summarizes the claims history, expenses, or types of claims by individuals for whom the Plan provides benefits, and from which the following information has been removed:

1. names;

2. geographic information more specific than state;

3. all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

4. other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

5. facial photographs or biometric identifiers (e.g., fingerprints); and

6. any information of which the Plan Sponsor has actual knowledge that could be used alone or in combination with other information to identify an individual.

7.02 **Disclosure of Summary Health Information**. Except as prohibited by 45 CFR §164.502(a)(5)(i), the Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

7.03 **Disclosure of Enrollment Information**. The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan.

7.04 **Disclosure of PHI**. The Plan will disclose PHI to the Plan Sponsor only in accordance with 45 CFR § 164.504(f) and the provisions of this Article.

7.05 **Certification**. This Article shall constitute certification by the Plan Sponsor that this Plan includes the provisions required under 45 CFR § 164.504(f).

7.06 **Plan Sponsor Obligations**. With respect to PHI, the Plan Sponsor agrees to:

a. Not use or disclose PHI other than as permitted or required by the Plan document or as required by law;

b. Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan Administrator agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

c. Not to use or disclose PHI for employment-related actions and decisions unless authorized by the Participant;

d. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the Participant;

e. Report to the Plan any PHI use or disclosure of information that is inconsistent with the uses or disclosures in this Article of which it becomes aware;

f. Make PHI available to the Participant in accordance with 45 CFR § 164.524;

g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

h. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

i. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining the Plan's compliance with 45 CFR Part 164;

j. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

k. Ensure that adequate separation between the Plan and the Plan Sponsor, as required by this Article and by 45 CFR § 164.504(f)(2)(iii), is established and maintained.

7.07 **Plan Sponsor's Access to PHI**. Adequate separation will be maintained between the Plan and the Plan Sponsor. Therefore, in accordance with HIPAA, only the Plan Administrator may be given access to PHI, and such person or entity may use and disclose PHI only for Plan administration functions that the Plan Sponsor performs.

7.08 **Noncompliance**. If the persons described herein or any other employees do not comply with the Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Plan Sponsor shall cooperate with the Plan Administrator to correct and mitigate any such noncompliance.

7.09 **Security of Electronic PHI.** The Plan Sponsor will reasonably and appropriately safeguard electronic PHI ("ePHI") created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan. Specifically, the Plan Sponsor will:

a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

b. Ensure that the adequate separation between the Plan and Plan Sponsor, as required by this Article and by 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

c. Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the ePHI; and

Report to the Plan any security incident concerning ePHI of which it becomes aware.

ARTICLE VIII

AMENDMENT AND TERMINATION

8.01 **Amendment.** Subject to the Agreement, the Employer may amend all or any part of this Plan at any time for any reason.

8.02 **Termination.** The Employer reserves the right, subject to the Agreement, to terminate or partially terminate the Plan, or discontinue Employer contributions to the Plan at any time. Nothing in the Plan is intended to or will be construed to entitle any Eligible Employee or other person to vested or non-terminable benefits.

8.03 **Effective Date of Amendment or Termination.** Subject to the Agreement, any such amendment, discontinuance or termination will be effective as of the date the Employer determines.

8.04 **Limitation of Obligations.** The Employer shall provide all benefits accrued by Eligible Employees under the Plan through its termination. No reimbursements shall be made for Covered Expenses incurred after the effective date of the Plan's termination.

ARTICLE IX

MISCELLANEOUS

9.01 **Limitation of Rights.** Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits under the Plan, shall be construed as giving to any Participant or other person any legal or equitable right against the Plan Sponsor, the Employer, the Plan Administrator, the Claims Administrator or the Plan, except as specifically provided in the documents setting forth the Plan.

9.02 **Restriction on Alienation.** The interests of persons entitled to benefits under the Plan are not subject to their debts or other obligations and, except as may be required by the tax withholding provisions of the Code or any state's income tax act, may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered.

9.03 **Facility of Payment**. When any person entitled to benefits under the Plan is disabled or is in any way incapacitated so as to be unable to manage his/her affairs, the Plan Administrator may cause such person's benefits to be paid to such person's legal representative for his/her benefit, or to be applied for the benefit of such person in any other manner that the Plan Administrator determines appropriate.

9.04 **Rescission**. Coverage under the Plan may be rescinded due to fraud or an intentional misrepresentation of material fact, or because the Participant knowingly provided the Plan Administrator or Claims Administrator with false information. Upon 30 days written notice, the Employer has the right to rescind coverage in such circumstances back to the effective date of coverage and to seek reimbursement of all expenses paid by the Plan.

9.05 **No Employment Contract.** This Plan is not an employment contract. Any employment rights of an Eligible Employee are neither enlarged nor diminished by the establishment of the Plan.

9.06 **Severability.** If any provision of the Plan is declared invalid or unenforceable by a court or agency of competent jurisdiction, such stricken provision shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

9.07 **Plan Provisions Control.** If any term or provision of any summary or description of this Plan is, in any construction, interpreted as being in conflict with a provision of this Plan, as set forth in this document, the provision of this Plan shall control.

9.08 **Notice**. Any notice to be delivered to a Participant or Qualified Beneficiary under this Plan shall be given in writing and delivered, personally or by first-class mail, postage prepaid, addressed to the Participant at his or her last known address. Any communication addressed to such Participant at the last known address shall be binding upon the Participant for all purposes of the Plan. Notwithstanding the foregoing, a Participant may be provided any notice required under this Plan via electronic delivery, to the extent the Participant consents to electronic receipt in a manner that reasonably demonstrates the Participant's ability to access the notice.

9.09 **Code and ERISA Compliance**. It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This

Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

9.10 **No Guarantee of Tax Consequences.** Neither the Employer nor the Claims Administrator make any commitment or guarantee that any amounts paid to or for the benefit of a Participant or Qualified Beneficiary under this Plan will be excludable from their gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant or Qualified Beneficiary to determine whether each payment under this Plan is excludable from their gross income for federal, state, and local income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Qualified Beneficiary is includable in their gross income for federal, state or local income tax purposes, then under no circumstances will the recipient have any recourse against the Employer, the Plan Administrator or the Claims Administrator with respect to any increased taxes or other losses or damages suffered by the Participant or Qualified Beneficiary as a result thereof

9.11 **Non-Assignability of Rights**. The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

9.12 **Gender/Number.** Whenever any words are used in this Plan in the masculine gender, they should be construed as though they were also used in the feminine gender in all situations where they would so apply; wherever any words are used in this Plan in the singular form, they should be construed as though they were also used in the plural form in all situations where they would so apply, and vice versa.

9.13 **Applicable Laws.** Except to the extent superseded by the laws of the United States, this Plan and all rights and duties thereunder shall be governed, construed, and administered in accordance with the laws of the State of California.

9.14 **Forum Selection.** Any court action must be brought in the U.S. District Court of the Northern District of California.

9.15 **Headings.** The headings and subheadings of this Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

9.16 **No Waiver of Terms.** No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan except by written agreement of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

CERTIFICATE OF EXECUTION

To record the establishment of the Plan, the Employer's authorized representative hereby executes this document on this 14th day of December, 2020.

OKTA, INC.

By: Sharpy Sandhu

Title: VP, Total Rewards

Date: 12/14/2020

EXHIBIT A

Covered Expenses

- Infertility care expenses include procedures and services to overcome an inability to have children, as indicated by a medical diagnosis of infertility, or to address other medical necessity.
- Covered infertility care expenses must be recommended and supervised by an eligible provider, subject to the following mandatory provisions:
    - Registered with the Society for Assisted Reproductive Technology (SART), or local equivalent
    - Reports data into SART, or local equivalent, on an annual basis
    - At least one board-certified reproductive endocrinologist on staff, or local equivalent
    - Offers vitrification freezing and single embryo transfers for PGS embryos
    - No exclusions for male fertility treatments
    - No exclusions for LGBTQ+
- Examples of covered treatments include but are not limited to:
    - Fertility consultations
    - Semen analysis
    - Fertility preservation for males and females
    - Genetic testing related to fertility (e.g., PGT-A, PGT-M)
    - Intrauterine insemination
    - In vitro fertilization
    - Transportation of reproductive material with an approved vendor
    - Storage costs for eggs, sperm, and/or embryos
    - Fertility medications
- The following treatments are examples of care that is not covered:
    - Infertility-related treatments under the care of primary care providers or OB/GYNs
    - Acupuncture
    - Herbal treatments
    - General genetic tests
    - Physical therapy or fitness-related expenses

EXHIBIT B

High Deductible Health Care Plans

- Blue Shield of California HDHP + HSA
  - Deductible (individual / family): $1,400 / $2,800
- Kaiser California HDHP + HSA
  - Deductible (individual / family): $1,400 / $2,800
- Kaiser Colorado HDHP + HSA
  - Deductible (individual / family): $1,400 / $2,800
- Kaiser Georgia HDHP + HSA
  - Deductible (individual / family): $1,400 / $2,800
- Kaiser Mid-Atlantic States HDHP + HSA
  - Deductible (individual / family): $1,400 / $2,800
- Kaiser Northwest HDHP + HSA
  - Deductible (individual / family): $1,400 / $2,800
- Kaiser Washington HDHP + HSA
  - Deductible (individual / family): $1,400 / $2,800

EXHIBIT C

List of Related Reimbursement Arrangements

1. Okta, Inc. Adoption Assistance Plan
2. Okta, Inc. Fertility Expense Reimbursement Program
3. Okta, Inc. Surrogacy and Gestational Carrier Expense Reimbursement Program