2026 Healthcare Comparisons

Side-by-side comparisons of your Okta medical, dental, and vision plans*

For details about all of Okta's benefits, go to rewards.okta.com.

**Not applicable for Hawaii employees enrolled in HMSA.*

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Medical and prescription drug coverage

The following table compares what you will pay for services under each of Okta's Blue Shield plans.

	Blue Shield HDHP + HSA		Blue Shield PPO		Blue Shield EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Deductible (Individual/Family)	$3,400/$6,800*	$6,800/$13,600*	$750/$2,250*	$2,250/$6,750*	$500/$1,000
Out-of-Pocket Maximum (Individual/Family)	$6,800/$13,600*	$13,600/$27,200*	$3,500/$7,000*	$7,000/$14,000*	$2,000/$4,000
Coinsurance	10%	20%	20%	40%	0%
Annual Wellness Exam	No charge, deductible waived	Not covered	No charge	Not covered	No charge
Office Visits (Primary/Specialist)	No charge**	20%**	$20	40%**	$15/$30
Mental Health and Substance Use Disorder Services	No charge**	**Office visits:** 20%** **Other services:** 20%**	**Office visits:** $20 **Other services:** 20%**	**Office visits:** 40%** **Other services:** 40%**	**Office visits:** $15 **Other services:** No charge
Telehealth Consultation	No charge**	Not covered	No charge	Not covered	No charge
Chiropractic Services	No charge,** up to 24 visits	20% per visit,** up to 24 visits	$20 per visit, up to 24 visits	40%,** up to 24 visits	$15 per visit, up to 20 visits
Acupuncture Services	No charge,** up to 12 visits	20% per visit,** up to 12 visits	$20 per visit, up to 12 visits	40%,** up to 12 visits	$15 per visit, up to 20 visits
Prescription Drugs (available through Express Scripts)					
Retail 30-Day Supply	**Tier 1:** $10** **Tier 2:** $25** **Tier 3:** $40** **Specialty:** 30% up to $200**	**Tier 1:** 25% plus $10** **Tier 2:** 25% plus $25** **Tier 3:** 25% plus $40** **Specialty:** Not covered**	**Tier 1:** $10 **Tier 2:** $20 **Tier 3:** $40 **Specialty:** 30% up to $200	**Tier 1:** 25% plus $10 **Tier 2:** 25% plus $20 **Tier 3:** 25% plus $40 **Specialty:** Not covered	**Tier 1:** $10 **Tier 2:** $20 **Tier 3:** $40 **Specialty:** 30% up to $200
Retail 90-Day Supply	**Tier 1:** $30** **Tier 2:** $75** **Tier 3:** $120** **Specialty:** 30% up to $600**	**Tier 1:** Not covered **Tier 2:** Not covered **Tier 3:** Not covered **Specialty:** Not covered	**Tier 1:** $30 **Tier 2:** $60 **Tier 3:** $120 **Specialty:** 30% up to $600	**Tier 1:** Not covered **Tier 2:** Not covered **Tier 3:** Not covered **Specialty:** Not covered	**Tier 1:** $30 **Tier 2:** $60 **Tier 3:** $120 **Specialty:** 30% up to $600
Mail Order 90-Day Supply	**Tier 1:** $20** **Tier 2:** $50** **Tier 3:** $80** **Specialty:** 30% up to $600**	**Tier 1:** Not covered **Tier 2:** Not covered **Tier 3:** Not covered **Specialty:** Not covered	**Tier 1:** $10 **Tier 2:** $40 **Tier 3:** $80 **Specialty:** 30% up to $600**	**Tier 1:** Not covered **Tier 2:** Not covered **Tier 3:** Not covered **Specialty:** Not covered	**Tier 1:** $10 **Tier 2:** $40 **Tier 3:** $80 **Specialty:** 30% up to $600**

**A member with family coverage will need to meet the individual deductible/out-of-pocket maximum prior to the family meeting the family deductible/out-of-pocket maximum within a calendar year.*

***After deductible.*

In addition to the Blue Shield plans, Okta offers two Kaiser plans. The following table compares what you will pay for services under both Kaiser plans.

	Kaiser HDHP + HSA	Kaiser HMO
	In-Network Only	In-Network Only
Deductible (Individual/Family)	$3,400/$6,800	$250/$500
Out-of-Pocket Maximum (Individual/Family)	$3,400/$6,800	**$2,000/$4,000**
Annual Wellness Exam	No charge, deductible waived	No charge
Office Visits (Primary/Specialist)	No charge*	$20/$30
Mental Health and Substance Use Disorder Services**	No charge*	$20
Telehealth Consultation	No charge*	No charge
Chiropractic Services	No charge,* up to 20 visits	$20 per visit, up to 20 visits
Acupuncture Services	**GA:** No charge,* up to 20 visits **WA:** No charge,* up to 12 visits **CA, MAS:** Not covered	**CA, GA, MAS, WA:** $20 per visit, up to 20 visits
Prescription Drugs (available through Kaiser network pharmacies)		
Retail	**No charge***	**CA:** Tier 1: $10, Tier 2: $30, Tier 3: $30, Specialty: 10%, up to $250 **GA:** Tier 1: $10, Tier 2: $30, Tier 3: $60, Specialty: 20%, up to $250 **MAS:** Tier 1: $10, Tier 2: $30, Tier 3: $60, Specialty: 10%, up to $150 **WA:** Tier 1: $10, Tier 2: $30, Tier 3: $60, Specialty: 20%, up to $250
Mail Order	**No charge***	**CA:** Tier 1: $20, Tier 2: $60, Tier 3: $60 **GA:** Tier 1: $20, Tier 2: $60, Tier 3: $120 **MAS:** Tier 1: $20, Tier 2: $60, Tier 3: $120 **WA:** Tier 1: $20, Tier 2: $60, Tier 3: $120

**After deductible.*

***For some Kaiser regions, group visits costs vary and can be lower.*

Note: Kaiser offers plans in California (CA), Georgia (GA), the mid-Atlantic states (MAS) which include Maryland, Washington D.C., and Virgina, and Washington (WA) state.

Dental coverage

The following table lists what you will pay for services under Okta's Delta Dental plan.

	Delta Dental	
	In-Network*	Out-of-Network
Deductible (Individual/Family)	$50/$150	$50/$150
Annual Benefit Maximum (Per Person)	$3,250	$2,250
Diagnostic & Preventive Care (Includes 3 Annual Cleanings)	No charge	No charge
Basic Services	10%**	20%**
Major Services	40%**	50%**
Orthodontics (Adult & Children)	50%	50%
Lifetime Benefit Maximum (Orthodontics)	$2,500	$2,500

**In-network coverage includes PPO Network and Premier Network dentists.*

***After deductible.*

Vision coverage

The following table lists what you will pay for services under Okta's VSP vision plan.

	VSP Vision	
	In-Network	Out-of-Network*
Coverage Frequency (Exam/Lens/Frames)	Every calendar year	Every calendar year
Eye Exam	$10	Plan pays up to $50
Single Lens	Included in prescription glasses, after you pay $25	Plan pays up to $50
Bifocal Lens	Included in prescription glasses, after you pay $25	Plan pays up to $75
Trifocal Lens	Included in prescription glasses, after you pay $25	Plan pays up to $100
Impact-Resistant Lenses (Dependent Children)	Included in prescription glasses, after you pay $25	N/A
Standard Progressive Lenses	No charge	Plan pays up to $75
Tints/Light-Reactive Lenses	No charge	Plan pays up to $5
Premium Progressive Lenses	$80-$90	Plan pays up to $75
Custom Progressive Lenses	$120-$160	Plan pays up to $75
UV Protection	No charge	No charge
Frames	Plan pays up to $180; or $100 when dispensed at Walmart®/Sam's Club®/Costco®	Plan pays up to $70
Contacts (Instead of Glasses)	Plan pays up to $150 for contacts; you pay up to $60 for exam and fitting	Plan pays up to $210 for necessary contact lenses

**Copay applies.*

Per-paycheck healthcare plan premiums

The amount you'll pay per paycheck for medical, dental, and vision coverage in 2026 is listed below. For premiums on other plans, go to rewards.okta.com.

Plan	Employee Only	Employee + Spouse/Partner*	Employee + Child(ren)*	Employee + Family
Blue Shield HDHP + HSA**	$18.46	$101.54	$76.15	$168.46
Blue Shield EPO**	$80.77	$240.00	$182.31	$373.85
Blue Shield PPO**	$90.00	$272.31	$219.23	$373.85
Kaiser HDHP + HSA (CA, GA, MAS, WA)	$18.46	$101.54	$76.15	$168.46
Kaiser HMO (CA, GA, MAS, WA)	$66.92	$198.46	$152.31	$265.38
Delta Dental	$0.00	$8.46	$11.69	$20.16
VSP Vision	$0.00	$0.89	$0.93	$2.27

**Premiums for your partner and your partner's child(ren) are subject to imputed income.*
***Available nationwide, except Hawaii.*

Employees in Hawaii can find monthly premiums for HMSA at rewards.okta.com.

Any descriptions of benefit plans contained in this document provide only general information. Employees should refer to their plan documents and summary plan descriptions at rewards.okta.com for full details of the plans' terms. If there is any discrepancy between the information provided in this document and the plan documents and/or summary plan descriptions, the plan documents and/or summary plan descriptions will govern.