

# 2027 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](https://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                                  |
| <b>Deductible</b><br>(Individual/Family)                 | \$3,500/\$7,000*             | \$7,000/\$14,000*                             | \$1,000/\$3,000*                             | \$3,000/\$9,000*                              | \$500/\$1,000                                    |
| <b>Out-of-Pocket Maximum</b><br>(Individual/Family)      | \$7,000/\$14,000*            | \$14,000/\$28,000*                            | \$3,500/\$7,000*                             | \$7,000/\$14,000*                             | \$2,500/\$5,000                                  |
| <b>Coinsurance</b>                                       | 10%                          | 20%                                           | 20%                                          | 40%                                           | 0%                                               |
| <b>Annual Wellness Exam</b>                              | No charge, deductible waived | Not covered                                   | No charge                                    | Not covered                                   | No charge                                        |
| <b>Office Visits</b><br>(Primary/Specialist)             | 10%**                        | 20%**                                         | \$20                                         | 40%**                                         | \$25/\$50                                        |
| <b>Mental Health and Substance Use Disorder Services</b> | 10%**                        | Office visits: 20%**<br>Other services: 20%** | Office visits: \$20<br>Other services: 20%** | Office visits: 40%**<br>Other services: 40%** | Office visits: \$25<br>Other services: No charge |
| <b>Telehealth Consultation</b>                           | No charge**                  | Not covered                                   | No charge                                    | Not covered                                   | No charge                                        |
| <b>Chiropractic Services</b>                             | 10%**; up to 24 visits       | 20% per visit**, up to 24 visits              | \$20 per visit, up to 24 visits              | 40%**; up to 24 visits                        | \$25 per visit, up to 20 visits                  |
| <b>Acupuncture Services</b>                              | 10%**; up to 12 visits       | 20% per visit**, up to 12 visits              | \$20 per visit, up to 12 visits              | 40%**; up to 12 visits                        | \$25 per visit, up to 20 visits                  |

## Prescription Drugs (available through Express Scripts)

|                                 |                                                                                    |                                                                                                         |                                                                            |                                                                                                   |                                                                            |
|---------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>Retail 30-Day Supply</b>     | Tier 1: \$10**<br>Tier 2: \$25**<br>Tier 3: \$40**<br>Specialty: 30% up to \$200** | Tier 1: 25% plus \$10**<br>Tier 2: 25% plus \$25**<br>Tier 3: 25% plus \$40**<br>Specialty: Not covered | Tier 1: \$10<br>Tier 2: \$30<br>Tier 3: \$60<br>Specialty: 30% up to \$200 | Tier 1: 25% plus \$10<br>Tier 2: 25% plus \$30<br>Tier 3: 25% plus \$60<br>Specialty: Not covered | Tier 1: \$10<br>Tier 2: \$30<br>Tier 3: \$60<br>Specialty: 30% up to \$200 |
| <b>Retail 90-Day Supply</b>     | Tier 1: \$30**<br>Tier 2: \$75**<br>Tier 3: \$120**<br>Specialty: Not covered      | Tier 1: Not covered<br>Tier 2: Not covered<br>Tier 3: Not covered<br>Specialty: Not covered             | Tier 1: \$30<br>Tier 2: \$90<br>Tier 3: \$180<br>Specialty: Not covered    | Tier 1: Not covered<br>Tier 2: Not covered<br>Tier 3: Not covered<br>Specialty: Not covered       | Tier 1: \$30<br>Tier 2: \$90<br>Tier 3: \$180<br>Specialty: Not covered    |
| <b>Mail Order 90-Day Supply</b> | Tier 1: \$20**<br>Tier 2: \$50**<br>Tier 3: \$80**<br>Specialty: Not covered       | Tier 1: Not covered<br>Tier 2: Not covered<br>Tier 3: Not covered<br>Specialty: Not covered             | Tier 1: \$10<br>Tier 2: \$60<br>Tier 3: \$120<br>Specialty: Not covered    | Tier 1: Not covered<br>Tier 2: Not covered<br>Tier 3: Not covered<br>Specialty: Not covered       | Tier 1: \$10<br>Tier 2: \$60<br>Tier 3: \$120<br>Specialty: Not covered    |

\*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.

Note that specialty drugs are only available through a 30-day supply via Accredo, Express Scripts' preferred specialty pharmacy.

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                 |
| <b>Deductible</b><br>(Individual/Family)                   | \$3,500/\$7,000                                                                            | \$500/\$1,000                   |
| <b>Out-of-Pocket Maximum</b><br>(Individual/Family)        | \$3,500/\$7,000                                                                            | \$2,500/\$5,000                 |
| <b>Annual Wellness Exam</b>                                | No charge, deductible waived                                                               | No charge                       |
| <b>Office Visits</b><br>(Primary/Specialist)               | No charge*                                                                                 | \$20/\$30                       |
| <b>Mental Health and Substance Use Disorder Services**</b> | No charge*                                                                                 | \$20                            |
| <b>Telehealth Consultation</b>                             | No charge*                                                                                 | No charge                       |
| <b>Chiropractic Services</b>                               | No charge,* up to 20 visits                                                                | \$20 per visit, up to 20 visits |
| <b>Acupuncture Services</b>                                | GA: No charge,* up to 20 visits<br>WA: No charge,* up to 12 visits<br>CA, MAS: Not covered | \$20 per visit, up to 20 visits |

#### Prescription Drugs (available through Kaiser network pharmacies)

|                   |            |                                                                                                                                                                                                                                                                                                                   |
|-------------------|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Retail</b>     | No charge* | CA: Tier 1: \$10, Tier 2: \$30, Tier 3: \$30, Specialty: 20%, up to \$250<br>GA: Tier 1: \$10, Tier 2: \$30, Tier 3: \$60, Specialty: 20%, up to \$250<br>MAS: Tier 1: \$10, Tier 2: \$30, Tier 3: \$60, Specialty: 20%, up to \$250<br>WA: Tier 1: \$10, Tier 2: \$30, Tier 3: \$60, Specialty: 20%, up to \$250 |
| <b>Mail Order</b> | No charge* | CA: Tier 1: \$20, Tier 2: \$60, Tier 3: \$60<br>GA: Tier 1: \$20, Tier 2: \$60, Tier 3: \$120<br>MAS: Tier 1: \$20, Tier 2: \$60, Tier 3: \$120<br>WA: Tier 1: \$20, Tier 2: \$60, Tier 3: \$120                                                                                                                  |

\*After deductible.

\*\*For some Kaiser regions, group visit 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 Virginia, and Washington (WA) state.

# Dental coverage

The following table lists what you will pay for in-network services under Okta's Delta Dental plans\*.

|                                                                        | Delta Dental          |                             |
|------------------------------------------------------------------------|-----------------------|-----------------------------|
|                                                                        | Base Plan             | Buy-Up Plan                 |
| <b>Deductible</b><br>(Individual/Family)                               | \$75/\$225            | \$50/\$150                  |
| <b>Annual Benefit Maximum</b><br>(Per Person)                          | \$2,250               | \$3,250                     |
| <b>Diagnostic and Preventive Care</b><br>(Includes 3 Annual Cleanings) | No charge             | No charge                   |
| <b>Basic Services</b>                                                  | 20%**                 | 10%**                       |
| <b>Major Services</b>                                                  | 50%**                 | 40%**                       |
| <b>Orthodontics</b>                                                    | 50% for children only | 50% for adults and children |
| <b>Lifetime Benefit Maximum</b><br>(Orthodontics)                      | \$1,500               | \$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*                                    |
| <b>Coverage Frequency</b><br>(Exam/Lens/Frames)        | Every calendar year                                                            | Every calendar year                                |
| <b>Eye Exam</b>                                        | \$10                                                                           | Plan pays up to \$50                               |
| <b>Single Lens</b>                                     | Included in prescription glasses after you pay \$25                            | Plan pays up to \$50                               |
| <b>Bifocal Lens</b>                                    | Included in prescription glasses after you pay \$25                            | Plan pays up to \$75                               |
| <b>Trifocal Lens</b>                                   | Included in prescription glasses after you pay \$25                            | Plan pays up to \$100                              |
| <b>Impact-Resistant Lenses</b><br>(Dependent Children) | Included in prescription glasses after you pay \$25                            | N/A                                                |
| <b>Standard Progressive Lenses</b>                     | No charge                                                                      | Plan pays up to \$75                               |
| <b>Tints/Light-Reactive Lenses</b>                     | No charge                                                                      | Plan pays up to \$5                                |
| <b>Premium Progressive Lenses</b>                      | \$80-\$90                                                                      | Plan pays up to \$75                               |
| <b>Custom Progressive Lenses</b>                       | \$120-\$160                                                                    | Plan pays up to \$75                               |
| <b>UV Protection</b>                                   | No charge                                                                      | No charge                                          |
| <b>Frames</b>                                          | Plan pays up to \$180, or \$100 when dispensed at Walmart®/Sam's Club®/Costco® | Plan pays up to \$70                               |
| <b>Contacts</b><br>(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 2027 is listed below. For premiums on other plans, go to [rewards.okta.com](https://rewards.okta.com).

| Plan                                   | Employee Only | Employee + Spouse/Partner* | Employee + Child(ren)* | Employee + Family |
|----------------------------------------|---------------|----------------------------|------------------------|-------------------|
| Blue Shield HDHP + HSA**               | \$27.69       | \$129.23                   | \$96.92                | \$212.31          |
| Blue Shield EPO**                      | \$99.23       | \$293.08                   | \$223.85               | \$456.92          |
| Blue Shield PPO**                      | \$113.08      | \$334.62                   | \$270.00               | \$459.23          |
| Kaiser HDHP + HSA<br>(CA, GA, MAS, WA) | \$27.69       | \$129.23                   | \$96.92                | \$212.31          |
| Kaiser HMO<br>(CA, GA, MAS, WA)        | \$73.85       | \$219.23                   | \$168.46               | \$293.08          |
| Delta Dental Base Plan                 | \$0.00        | \$8.46                     | \$11.69                | \$20.16           |
| Delta Dental Buy-Up Plan               | \$2.40        | \$11.95                    | \$15.92                | \$28.24           |
| 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](https://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](https://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.