Exhibit 5

TRICARE Supplement Plan Designs

### [Supplier Name]

### Plan Year 2022

Complete a grid for each type of supplement offered.

Type of Supplement (Check one):

\_\_\_\_TRICARE Standard

\_\_\_\_TRICARE Extra

\_\_\_\_TRICARE Prime

\_\_\_\_TRICARE Reserve/Select

|  |  |  |  |
| --- | --- | --- | --- |
|  | TRICARE Pays | Supplement Pays | Participant Pays |
| Inpatient Facility Services in civilian hospitals (room, board, supplies and staff services billed by hospital |  |  |  |
| Inpatient Professional Services in civilian hospitals (doctors and other inpatient services not billed by hospital) |  |  |  |
| Inpatient Care in government hospitals |  |  |  |
| Outpatient Care (office visits, clinics, lab, etc.) |  |  |  |
| Prescription Drugs (network civilian pharmacy) |  |  |  |
| Prescriptions (mail order home delivery) |  |  |  |
| Prescriptions (civilian non-network) |  |  |  |
| Other Charges (deductibles, excess charges, etc.) |  |  |  |

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Signature Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title Supplier Name

(To be signed by the Supplier’s President, Chief Executive

Officer or authorized representative.)