members, whose enrollment is mandatory.)

(1) Open Enrollment. Beneficiaries will be offered the opportunity to enroll in Prime on a continuing basis.

(2) Enrollment period. The Prime enrollment period shall be 12 months. Enrollees must remain in Prime for a 12 month period, at which time they may disenroll. This requirement is subject to exceptions for change of residence and other changes announced at the time the TRICARE program is implemented in a particular area.

(3) Quarterly installment payments of enrollment fee. The enrollment fee required by § 199.18(c) may be paid in quarterly installments, each equal to one-fourth of the total amount, plus an additional maintenance fee of \$5.00 per installment. For any beneficiary paying his or her enrollment fee in quarterly installments, failure to make a required installment payment on a timely basis (including a grace period, as determined by the Director, OCHAMPUS) will result in termination of the beneficiary's enrollment in Prime and disqualification from future enrollment in Prime for a period of one year.

(4) Period revision. Periodically, certain features, rules or procedures of Prime, Extra and/or Standard may be revised. If such revisions will have a significant effect on participants' costs or access to care, beneficiaries will be given the opportunity to change their enrollment status coincident with the

(5) Effects of failure to enroll. Beneficiaries offered the opportunity to enroll in Prime, who do not enroll, will remain in Standard and will be eligible to participate in Extra on a case-by-case

(p) Civilian preferred provider networks. A major feature of the TRICARE program is the civilian preferred provider network.

(1) Status of network providers. Providers in the preferred provider network are not employees or agents of the Department of Defense or the United States Government. Rather, they are independent contractors of the government (or other independent entities having business arrangements with the government). Although network providers must follow numerous rules and procedures of the TRICARE program, on matters of professional judgment and professional practice, the network provider is independent and not operating under the direction and control of the Department of Defense. Each preferred provider must have adequate professional liability insurance, as required by the Federal Acquisition

Regulation, and must agree to indemnify the United States Government for any liability that may be assessed against the United States Government that is attributable to any action or omission of the provider.

(2) Utilization management policies. Preferred providers are required to follow the utilization management policies and procedures of the TRICARE program. These policies and procedures are part of discretionary judgments by the Department of Defense regarding the methods of delivering and financing health care services that will best achieve health and economic policy objectives.

(3) Quality assurance requirements. A number of quality assurance requirements and procedures are applicable to preferred network providers. These are for the purpose of assuring that the health care services paid for with government funds meet the standards called for in the contract or provider agreement.

(4) Provider qualifications. All preferred providers must meet the following qualifications:

(i) They must be CHAMPUS authorized providers and CHAMPUS

participating providers.

(ii) All physicians in the preferred provider network must have staff privileges in a hospital accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). This requirement may be waived in any case in which a physician's practice does not include the need for admitting privileges in such a hospital, or in locations where no JCAHO accredited facility exists. However, in any case in which the requirement is waived, the physician must comply with alternative qualification standards as are established by the MTF Commander (or other authorized official).

(iii) All preferred providers must agree to follow all quality assurance, utilization management, and patient referral procedures established pursuant to this section, to make available to designated DoD utilization management or quality monitoring contractors medical records and other pertinent records, and to authorize the release of information to MTF Commanders regarding such quality assurance and utilization management activities.

(iv) All preferred network providers must be Medicare participating providers, unless this requirement is waived based on extraordinary circumstances. This requirement that a provider be a Medicare participating provider does not apply to providers not eligible to be participating providers under Medicare.

(v) The provider must be available to Extra participants.

(vi) The provider must agree to accept the same payment rates negotiated for Prime enrollees for any person whose care is reimbursable by the Department of Defense, including, for example, Extra participants, supplemental care cases, and beneficiaries from outside the

(vii) All preferred providers must meet all other qualification requirements, and agree to comply with all other rules and procedures established for the preferred provider network.

(5) Access standards. Preferred provider networks will have attributes of size, composition, mix of providers and geographical distribution so that the networks, coupled with the MTF capabilities, can adequately address the health care needs of the enrollees. Before offering enrollment in Prime to a beneficiary group, the MTF Commander (or other authorized person) will assure that the capabilities of the MTF plus preferred provider network will meet the following access standards with respect to the needs of the expected number of enrollees from the beneficiary group being offered enrollment:

(i) Under normal circumstances. enrollee travel time may not exceed 30 minutes from home to primary care delivery site unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area.

(ii) The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment shall not exceed one week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours

(iii) Emergency services shall be available and accessible to handle emergencies (and urgent care visits if not available from other primary care providers pursuant to paragraph (p)(5)(ii) of this section), within the service area 24 hours a day, seven days a week

(iv) The network shall include a sufficient number and mix of board certified specialists to meet reasonably the anticipated needs of enrollees. Travel time for specialty care shall not exceed one hour under normal circumstances, unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area. This requirement does not apply under the **Specialized Treatment Services** Program.