Fact sheet

Understanding Your Medicare Advantage Plan's Provider Network

Many Medicare Advantage Plans have networks that include doctors, other health care providers, hospitals, and facilities. Your health insurer or plan has contracted with these providers to give health care services. It's important to understand your plan's provider network to make sure you get the care you need at the lowest cost.

You can find your plan's provider directory on your Medicare Advantage Plan's website, or contact your plan and ask for a provider directory.

In some Medicare Advantage Plans, when you choose a primary care doctor, you're also choosing the hospitals and specialty networks associated with that doctor. If there's a particular hospital or health care provider you want to use, you may need to ask your primary care doctor for a referral.

In many cases, you can only use doctors and other providers who are in the plan's network and service area (for non-emergency care). Some plans offer non-emergency coverage out of network, but typically at a higher cost.

Can my plan change its provider network?

- Yes. Your Medicare Advantage Plan can add or remove providers from its network at any time during the year.
- Even though your Medicare Advantage Plan can change its network at any time, your plan must protect you from interruptions in medical care and must make sure you have access to medically necessary covered benefits.
- If you believe a network change will cause an interruption in your medical care and put your health at risk, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Can my provider leave my plan's network?

- Your provider can choose to leave your plan's network at any time. If your provider is no longer in network, you'll need to choose a new provider in your plan's network to get covered services.
- Your plan should make a good faith effort to give you at least 30 days' notice that your provider is leaving their network so you have time to choose a new provider. Your plan will notify you if a provider you go to regularly (like your primary care provider) is leaving their network.
- Check with your provider when you schedule an appointment to confirm they're still in your plan's network.
- Each year, during the Medicare Open Enrollment Period (October 15 – December 7), check to find out if your providers are in the plans you're considering.

What questions should I ask my plan about its network?

- How can I find out if my providers are in the plan's network?
- How much do I pay for services in network?
- How much do I pay for services out of network?
- What if I need covered treatments that aren't available from a provider in the plan's network?

How do provider networks work in different types of plans?

Health Maintenance Organization (HMO) Plans

In HMO plans, you generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or temporary out-of-area dialysis, which is covered whether it's provided in the plan's network or outside the plan's network). In an HMO with a point-of-service (POS) option, you may be able to go out-of-network for certain services (usually for a higher cost).

Preferred Provider Organization (PPO) Plans

Generally, you can get your health care from any doctor, other health care provider, or hospital in a PPO's network.

You can also go to doctors, other health care providers, or hospitals that aren't in the plan's network, but it usually costs more.

Private Fee-for-Service (PFFS) Plans

If you join a PFFS plan that has a network, you can go to any of the network providers who have agreed to treat you. You can also choose an out-of-network doctor, other health care provider, or hospital that accepts the plan's terms, but it may cost more.

If you join a PFFS plan that doesn't have a network, you can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. Not all providers will.

In a medical emergency, doctors, other health care providers, and hospitals must treat you.

Special Needs Plans (SNP)

A Special Needs Plan gives benefits and services to people with specific severe and chronic diseases, certain health care needs, or who also have Medicaid. Check with your plan to find out if they require a primary doctor. SNPs typically have specialists in the diseases or conditions that affect their members.

Some SNPs require that you get your care and services from providers and facilities in the plan's network (except for emergency care, out-of-area urgent care, or out-of-area dialysis). Other SNPs offer out-of-network coverage, so you can get services from any qualified provider or facility, but you'll usually pay more.

Notes

Medicare

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

This product was produced at U.S. taxpayer expense.

CMS Product No. 11941 • 01/2025