

Health Insurance Marketplace



What You Should Know About Provider Networks

What's a provider network?

A provider network is a list of doctors, other health care providers, and hospitals that a plan contracts with to provide medical care to its members. They're known as "network providers" or "in-network providers." A provider that isn't contracted with the plan is called an "out-of-network provider."

How can I check if my doctor is in a plan's network before I choose a Health Insurance Marketplace® Plan?

"Providers" can include doctors, psychologists, or physical therapists, and health care facilities like hospitals, urgent care clinics, or pharmacies.

Insurance companies may have different networks for different plans, so make sure you search the provider network of each specific plan you compare. You can also call the insurance company's customer service phone number to find out if your providers are in the plan's network. If you travel a lot, check if the plan's network has providers where you might need care.

What should I know before I apply?

Visit [HealthCare.gov/see-plans](https://www.healthcare.gov/see-plans) to compare Marketplace plans and estimated prices before you enroll. Make a list of all the providers you use. When you compare plans, search for your doctors and health care facilities. You can also check if each plan includes your doctors and facilities in its network.

Once you find a plan you like, print or email the information so you'll have the full plan name and 14 character ID (that's a combination of numbers and/or letters) when you're ready to apply through the Marketplace and enroll.

What should I know when I apply?

When you apply for coverage through the Marketplace, you can compare plans and prices, and find out about any savings you may qualify for to help lower your monthly premiums. You can search for specific plans, providers, or facilities, or by Plan ID. Each plan description includes a link to its provider directory. If you want coverage for dependents, search for their doctors and facilities too.

How do different types of plans use provider networks?

Depending on the type of plan you buy, your plan may cover your care only when you go to a network provider. You may have to pay more, and/or get a referral if you choose to get care from a provider who isn't in your plan's network. Types of plans include:

- **Preferred Provider Organizations (PPOs):** You pay less if you use providers in the plan's network. For an additional cost, you can use doctors, hospitals, and health care providers outside of the network without a referral.
- **Point-of-Service (POS) Plans:** You pay less if you use doctors, hospitals, and other providers that belong to the plan's network. You're required to get referrals from your primary care doctor to go to specialists.
- **Health Maintenance Organizations (HMOs):** You're usually limited to care from doctors who work for or contract with the HMO and aren't covered for out-of-network care (except in an emergency). You may be required to live or work in the HMO's service area to qualify for coverage.
- **Exclusive Provider Organizations (EPOs):** You're only covered if you use doctors, specialists, or hospitals in the plan's network (except in an emergency).

Where can I find the plan type when I'm shopping in the Marketplace?

When comparing plans on [HealthCare.gov](https://www.healthcare.gov), the plan type is listed immediately below its name. Look for the initials PPO, POS, HMO, or EPO. The type of plan is also listed on each plan's "Summary of Benefits and Coverage." If you're not sure what the plan type is or you want to know more about the coverage it offers, call the health insurance company directly. You can also call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325). To find in-person assistance in your area, visit [HealthCare.gov/find-local-help](https://www.healthcare.gov/find-local-help).

Why do some plans cover benefits and services from network providers, but not from out-of-network providers?

Network providers offer benefits or services to the plan's members at prices that the provider and the plan agreed on. This generally means that they provide a covered benefit at a lower cost to the plan and the plan's members than to someone without insurance or someone in a plan where the provider is out-of-network.

All Marketplace plans must have provider networks with enough types of providers to ensure that their plan members can get plan services without unreasonable delay. Depending on your plan, if you use an out-of-network provider, you might have to pay the full cost of the benefits and services you get from that provider, except for emergency services.

Insurance plans can't make you pay more in copayments or coinsurance if you get emergency care from an out-of-network hospital. They also can't make you get prior approval before getting emergency services from a provider or hospital outside your plan's network. However, you may have to pay some out-of-pocket costs, like a deductible, at the in-network rates. Plans aren't allowed to charge you out-of-network cost-sharing (like out-of-network coinsurance or copayments) for emergency and certain non-emergency services.

What can I do if I enroll in a Marketplace plan, but my doctor isn't in my plan's network?

If you enroll in a Marketplace plan and find out that your doctor isn't in the plan's network, you can switch to another plan during Open Enrollment. Find out when your new coverage starts before you cancel your current plan, so you won't have a gap in coverage. If you decide to switch plans, make sure your doctor is in your new plan's provider network. You can find a link to a list of providers in each plan's network in the plan description in your Marketplace account. You can also contact your health insurance company to discover which doctors, hospitals, and other health care providers are in your plan's network.

After your coverage starts, you won't be able to change your plan until Open Enrollment (November 1 - January 15), unless you get a Special Enrollment Period because you experience certain life events. Examples of qualifying life events include losing health coverage, getting married, moving, or having a baby. Visit [HealthCare.gov/reporting-changes](https://www.healthcare.gov/reporting-changes) if you need to update your application because of a life event.

You can contact your plan to request an exception for out-of-network care to be covered like in-network care. You may also qualify as a continuing care patient if you're getting treatment from a provider or facility and your health plan terminates your provider's contract. Contact your plan to discover if you qualify for in-network exceptions or continuity of care.

If you go to your doctor and find out later that your new plan doesn't cover your doctor or doesn't pay for the visit, you have the right to appeal the decision and have it reviewed by an independent third party. Visit [HealthCare.gov/appeal-insurance-company-decision](https://www.healthcare.gov/appeal-insurance-company-decision) to learn about the appeals process.

How can I learn more?

To learn more about coverage through the Marketplace or your benefits and protections, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596.

TTY users can call 1-855-889-4325.

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You have the right to get your 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 [CMS.gov/accessibility-nondiscrimination](https://www.cms.gov/accessibility-nondiscrimination), or call 1-800-318-2596. TTY users can call 1-855-889-4325.

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