Health Insurance Jargon Can Be Frustrating and Confusing – Here's How to Navigate It

Make informed decisions about your health care by understanding your insurance plan.

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Since the Affordable Care Act subsidies expired at the end of 2025, Americans have undoubtedly been encountering a great deal of confusing information surrounding health care costs and insurance plans.

From five-figure deductibles to premiums higher than people's mortgages, costs are rising across the board.

With this comes difficult decisions around health care plan enrollment. No one can know exactly what their health care needs will be in any given year, so people are forced to hedge their bets in choosing plans.

What plan you pick has a huge impact on what you will end up paying.

However, many Americans don't understand key health insurance terms. For example, people who've completed fewer levels of education and people without health insurance are less likely to understand the jargon. This can get in the way of picking the right plans.

As scholars of health policy, evidence-based health care and health economics, we believe understanding these terms can help you pick what plan might be the best for you.

Frequently encountered health insurance terms

The first of these is your health insurance premium. This is the amount you pay each month for having health insurance coverage, whether or not you use any services. Premiums can be expensive, but they are predictable. Once your premium is set for the year, it won't change.

What's much harder to predict is how much of each medical bill you will have to pay yourself, known as out-of-pocket costs. These are sometimes also referred as "patient cost-sharing" or

“copays.” These typically come in three forms: deductibles, coinsurance and copayments.

A deductible is how much you need to spend on your health care in a given year before your insurance starts covering any costs. Under plans with a deductible, you pay the full cost of health care services first – essentially as if you did not have health insurance – until your total spending reaches the deductible amount. Once you reach that threshold, your insurance will start paying for your additional medical costs.

But in most plans, even once you hit your deductible, your insurance will still not cover the full cost of your care. You will continue to pay a portion of the bill through coinsurance, which is the percentage of the cost of care that you are responsible for paying. For example, if your coinsurance rate is 20% and you receive care that costs US$500, you would pay $100 (20% of $500).

What often makes coinsurance confusing is that while the coinsurance rate – the percentage – is usually listed on your health insurance card, you still need to know the total cost of your care to calculate how much you will owe. That cost is difficult to know in advance because reliable health care prices are difficult to find and health care needs – and the services required to treat them – can be unpredictable.

Then there are copayments. This is a fixed amount you pay for a health care encounter, such as $20 for a primary care visit or $150 for an emergency department visit. In everyday language, people sometimes use copay to refer to any amount a patient pays out of pocket. Technically, however, a copayment refers only to a fixed fee paid for a health care service.

Whether through deductibles, coinsurance or copayments, these out-of-pocket amounts can add up quickly. To protect patients, especially those who need a lot of care and could otherwise face devastating medical bills, federal regulations require health insurers to limit how much patients can be asked to pay out of pocket each year for covered services.

This amount is called the out-of-pocket maximum. This is sometimes also called the out-of-pocket cap or out-of-pocket limit. Once your total out-of-pocket spending reaches that limit, your insurance must pay 100% of the cost of additional covered services for the rest of the year.

Additional factors to consider

These insurance rules can become even more complicated. Many plans have multiple different deductible amounts, coinsurance rates, copayments and even out-of-pocket maximums, depending on several factors. For example, in family plans, each person may have their own deductible or out-of-pocket maximum, but there may also be thresholds and limits that apply to the family as a whole. Cost-sharing can also vary by the type of care you receive. For instance, inpatient hospital care may be subject to a different set of cost-sharing rules than outpatient care.

Another important factor is whether your health care provider has a contract with your insurance

company. Providers who have such a contract are called in-network providers. Those who do not are called out-of-network providers. Some insurance plans further divide in-network providers into tiers.

Providers in Tier 1 are the most preferred by the insurance plan, often because they agreed to provide services at relatively lower prices. Other in-network providers may be placed in Tier 2. Costs to you tend to be lowest for services from Tier 1 providers, higher for services from Tier 2 providers and highest for services from out-of-network providers. Some insurance plans may not cover out-of-network care at all.

There are often trade-offs between these elements – low premiums look great on the face of it, but any money you save by paying lower premiums is often offset by significant out-of-pocket costs, limited options for in-network providers, or both.

The problem, of course, is that it's impossible to predict how much health care you might need. If you could somehow know you weren't going to need much health care in the following year, then a low-premium, high-deductible plan would make sense.

If, on the other hand, you knew you were going to receive a catastrophic diagnosis or be in a life-altering car accident, you would want to opt for a plan that might include higher premiums but lower copays.

Gambles and trade-offs

If everyone knew all the medical care they needed could be provided by any general doctor, they might not care much about what or who was in-network. But if they knew they were going to need specialist surgery for a rare type of tumor, for example, offered at only one center out of state, they would want to consider what counts as in-network – or the costs of going out of network – in substantially more detail.

In many other countries, people don't face the same burden. In nations with universal health coverage, understanding health insurance jargon isn't a matter of financial survival. Because coverage is guaranteed, people do not have to agonize every year over choosing a health plan based on countless variables.

But until meaningful change comes about in the U.S., the best many Americans can do is understand health insurance jargon so they can choose plans that work best for them.

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