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Electronic Data Interchange (EDI)	Electronic data interchange (EDI) is the computer-to-computer delivery of information. EDI makes electronic communications a viable method of streamlining claims processing and eliminating wasted time and money. EDI transactions provide convenience, efficiency, and transactional record management.
Electronic Funds Transfer (EFT)	A secure electronic process which directs Highmark claim payments to the practitioner's checking or savings account as directed by your office.
Electronic Health Record (EHR)	The aggregate electronic record of health-related information on an individual that is created and gathered cumulatively across more than one health care organization, and is managed and consulted by licensed clinicians and staff involved in the individual's health and care.
Electronic Medical Record (EMR)	The electronic record of health-related information on an individual that is created, gathered, managed, and consulted by licensed clinicians and staff from a single organization who are involved in the individual's health and care.
Electronic Provider Access (EPA)	The Blue Cross and Blue Shield Plans tool that gives providers the ability to access an out-of-area member's Blue Plan (Home Plan) provider portal to conduct electronic pre-service review. The term preservice review is used to refer to pre-notification, pre-certification, preauthorization, and prior approval, amongst other pre-claim processes. Electronic Provider Access (EPA) enables providers to use their local Blue Plan provider portal to gain access to an out-of-area member's Home Plan provider portal through a secure routing mechanism. Once in the Home Plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Home Plan's local providers.
Electronic Remittance Advice (ERA)	This HIPAA 835 electronic transaction contains finalized claim payment information, including payment when issued, used for automated account posting.
Emergency: Life-Threatening	Immediate intervention is required to prevent death or serious harm to patient or others.
Emergency: Non-Life Threatening	Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety.
Emergency Medical Condition	An emergency medical condition (as defined by the Balanced Budget Act [BBA] of 1997) is: A condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Service	An emergency service is any health care service provided to a member after sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: • Placing the health of the enrollee, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any body organ or part.
End Stage Renal Disease (ESRD)	End stage renal disease (ESRD) is permanent kidney failure that requires kidney dialysis or a transplant to maintain life.
Essential Health Benefits (EHB)	Essential Health Benefits are defined as a set of health care services that must be covered by certain health plans -- such as Highmark. The Affordable Care Act (ACA) ensures that health plans offer to the individual and small group markets, both inside and outside of the Health Insurance Marketplace, a comprehensive package of items and services, known as essential health benefits. These benefits must include items and services within the following categories: • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services • Chronic disease management • Pediatric services, including oral and vision care Insurance companies, such as Highmark, must cover these benefits in order to be certified and offer products through the Health Insurance Marketplace.
e-Subscribe	The e-Subscribe feature available on the Provider Resource Center allows you to sign-up for electronic delivery of various online publications and information updates. The latest Highmark news and updates arrive in your email inbox with timely, up-to-date information at your fingertips.
Exclusions and Limitations	Items or services that are not covered as part of a program.
Exclusive Provider Organization (EPO)	Exclusive Provider Organizations (EPOs) provide members with coverage for a wide range of services when they are received from in-network providers and facilities. EPOs function like a PPO but offer no out-of-network benefits except for emergency services. Members are not required to select a PCP to coordinate covered care, but it is recommended. By utilizing the local Blue Plan PPO network, EPOs allow access to the largest provider network in the Highmark service area, as well as a large provider network across the country.

Expedited Grievance (for managed care per PA Act 68)	In Pennsylvania, an expedited grievance is a request for an expedited review of an initial adverse benefit determination for medical, pharmaceutical, or behavioral health services based on medical necessity and appropriateness when: 1) A delay in decision making might jeopardize the member's life, health or ability to regain maximum functions based on a prudent layperson's judgment and confirmed by the treating practitioner; or 2) In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; or 3) It is concerning the admission, continued stay or other health care services for a member who has received emergency services, but has not been discharged from a facility; or 4) It is concerning a concurrent review.
Expedited Provider Appeal	An expedited provider appeal is used when a member is receiving an ongoing service or is scheduled to receive a service for which coverage has been denied and the seriousness of the circumstances require that the appeal be reviewed quickly because the physician believes that the lack of service will adversely affect the member's health.