AN ACT concerning civil law.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Department of Central Management Services Law of the Civil Administrative Code of Illinois is amended by changing Sections 405-105 and 405-411 as follows:

(20 ILCS 405/405-105) (was 20 ILCS 405/64.1)

Sec. 405-105. Fidelity, surety, property, and casualty insurance. The Department shall establish and implement a program to coordinate the handling of all fidelity, surety, property, and casualty insurance exposures of the State and the departments, divisions, agencies, branches, and universities of the State. In performing this responsibility, the Department shall have the power and duty to do the following:

(1) Develop and maintain loss and exposure data on all State property.

(2) Study the feasibility of establishing a self-insurance plan for State property and prepare estimates of the costs of reinsurance for risks beyond the realistic limits of the self-insurance.

(3) Prepare a plan for centralizing the purchase of property and casualty insurance on State property under a master policy or policies and purchase the insurance

contracted for as provided in the Illinois Purchasing Act.

(4) Evaluate existing provisions for fidelity bonds required of State employees and recommend changes that are appropriate commensurate with risk experience and the determinations respecting self-insurance or reinsurance so as to permit reduction of costs without loss of coverage.

(5) Investigate procedures for inclusion of school districts, public community college districts, and other units of local government in programs for the centralized purchase of insurance.

(6) Implement recommendations of the State Property Insurance Study Commission that the Department finds necessary or desirable in the performance of its powers and duties under this Section to achieve efficient and comprehensive risk management.

(7) Prepare and, in the discretion of the Director, implement a plan providing for the purchase of public liability insurance or for self-insurance for public liability or for a combination of purchased insurance and self-insurance for public liability (i) covering the State and drivers of motor vehicles owned, leased, or controlled by the State of Illinois pursuant to the provisions and limitations contained in the Illinois Vehicle Code, (ii) covering other public liability exposures of the State and its employees within the scope of their employment, and (iii) covering drivers of motor vehicles not owned, leased,

or controlled by the State but used by a State employee on State business, in excess of liability covered by an insurance policy obtained by the owner of the motor vehicle or in excess of the dollar amounts that the Department shall determine to be reasonable. Any contract of insurance let under this Law shall be by bid in accordance with the procedure set forth in the Illinois Purchasing Act. Any provisions for self-insurance shall conform to subdivision (11).

The term "employee" as used in this subdivision (7) and in subdivision (11) means a person while in the employ of the State who is a member of the staff or personnel of a State agency, bureau, board, commission, committee, department, university, or college or who is a State officer, elected official, commissioner, member of or ex officio member of a State agency, bureau, board, commission, committee, department, university, or college, or a member of the National Guard while on active duty pursuant to orders of the Governor of the State of Illinois, or any other person while using a licensed motor vehicle owned, leased, or controlled by the State of Illinois with the authorization of the State of Illinois, provided the actual use of the motor vehicle is within the scope of that authorization and within the course of State service.

Subsequent to payment of a claim on behalf of an

employee pursuant to this Section and after reasonable advance written notice to the employee, the Director may exclude the employee from future coverage or limit the coverage under the plan if (i) the Director determines that the claim resulted from an incident in which the employee was grossly negligent or had engaged in willful and wanton misconduct or (ii) the Director determines that the employee is no longer an acceptable risk based on a review of prior accidents in which the employee was at fault and for which payments were made pursuant to this Section.

The Director is authorized to promulgate administrative rules that may be necessary to establish and administer the plan.

Appropriations from the Road Fund shall be used to pay auto liability claims and related expenses involving employees of the Department of Transportation, the Illinois State Police, and the Secretary of State.

(8) Charge, collect, and receive from all other agencies of the State government fees or monies equivalent to the cost of purchasing the insurance.

(9) Establish, through the Director, charges for risk management services rendered to State agencies by the Department. The State agencies so charged shall reimburse the Department by vouchers drawn against their respective appropriations. The reimbursement shall be determined by the Director as amounts sufficient to reimburse the

Department for expenditures incurred in rendering the service.

The Department shall charge the employing State agency or university for workers' compensation payments for temporary total disability paid to any employee after the employee has received temporary total disability payments for 120 days if the employee's treating physician has issued a release to return to work with restrictions and the employee is able to perform modified duty work but the employing State agency or university does not return the employee to work at modified duty. Modified duty shall be duties assigned that may or may not be delineated as part of the duties regularly performed by the employee. Modified duties shall be assigned within the prescribed restrictions established by the treating physician and the physician who performed the independent medical examination. The amount of all reimbursements shall be deposited into the Workers' Compensation Revolving Fund which is hereby created as a revolving fund in the State treasury. In addition to any other purpose authorized by law, moneys in the Fund shall be used, subject to appropriation, to pay these or other temporary total disability claims of employees of State agencies and universities.

Beginning with fiscal year 1996, all amounts recovered by the Department through subrogation in workers'

compensation and workers' occupational disease cases shall be deposited into the Workers' Compensation Revolving Fund created under this subdivision (9).

(10) Establish rules, procedures, and forms to be used by State agencies in the administration and payment of workers' compensation claims. The Department shall initially evaluate and determine the compensability of any injury that is the subject of a workers' compensation claim and provide for the administration and payment of such a claim for all State agencies. The Director may delegate to any agency with the agreement of the agency head the responsibility for evaluation, administration, and payment of that agency's claims.

(10a) If the Director determines it would be in the best interests of the State and its employees, prepare and implement a plan providing for: (i) the purchase of workers' compensation insurance for workers' compensation liability; (ii) third-party administration of self-insurance, in whole or in part, for workers' compensation liability; or (iii) a combination of purchased insurance and self-insurance for workers' compensation liability, including reinsurance or stop-loss insurance. Any contract for insurance or third-party administration shall be on terms consistent with State policy; awarded in compliance with the Illinois Procurement Code; and based on, but not limited to, the

following criteria: administrative cost, service capabilities of the carrier or other contractor and premiums, fees, or charges. By April 1 of each year, the Director must report and provide information to the State Workers' Compensation Program Advisory Board concerning the status of the State workers' compensation program for the next fiscal year. Information includes, but is not limited to, documents, reports of negotiations, bid invitations, requests for proposals, specifications, copies of proposed and final contracts or agreements, and any other materials concerning contracts or agreements for the program. By the first of each month thereafter, the Director must provide updated, and any new, information to the State Workers' Compensation Program Advisory Board until the State workers' compensation program for the next fiscal year is determined.

(11) Any plan for public liability self-insurance implemented under this Section shall provide that (i) the Department shall attempt to settle and may settle any public liability claim filed against the State of Illinois or any public liability claim filed against a State employee on the basis of an occurrence in the course of the employee's State employment; (ii) any settlement of such a claim is not subject to fiscal year limitations and must be approved by the Director and, in cases of settlements exceeding $100,000, by the Governor; and (iii) a settlement

of any public liability claim against the State or a State employee shall require an unqualified release of any right of action against the State and the employee for acts within the scope of the employee's employment giving rise to the claim.

Whenever and to the extent that a State employee operates a motor vehicle or engages in other activity covered by self-insurance under this Section, the State of Illinois shall defend, indemnify, and hold harmless the employee against any claim in tort filed against the employee for acts or omissions within the scope of the employee's employment in any proper judicial forum and not settled pursuant to this subdivision (11), provided that this obligation of the State of Illinois shall not exceed a maximum liability of $2,000,000 for any single occurrence in connection with the operation of a motor vehicle or $100,000 per person per occurrence for any other single occurrence, or $500,000 for any single occurrence in connection with the provision of medical care by a licensed physician employee.

Any claims against the State of Illinois under a self-insurance plan that are not settled pursuant to this subdivision (11) shall be heard and determined by the Court of Claims and may not be filed or adjudicated in any other forum. The Attorney General of the State of Illinois or the Attorney General's designee shall be the attorney with

respect to all public liability self-insurance claims that are not settled pursuant to this subdivision (11) and therefore result in litigation. The payment of any award of the Court of Claims entered against the State relating to any public liability self-insurance claim shall act as a release against any State employee involved in the occurrence.

(12) Administer a plan the purpose of which is to make payments on final settlements or final judgments in accordance with the State Employee Indemnification Act. The plan shall be funded through appropriations from the General Revenue Fund specifically designated for that purpose, except that indemnification expenses for employees of the Department of Transportation, the Illinois State Police, and the Secretary of State shall be paid from the Road Fund. The term "employee" as used in this subdivision (12) has the same meaning as under subsection (b) of Section 1 of the State Employee Indemnification Act. Subject to sufficient appropriation, the Director shall approve payment of any claim, without regard to fiscal year limitations, presented to the Director that is supported by a final settlement or final judgment when the Attorney General and the chief officer of the public body against whose employee the claim or cause of action is asserted certify to the Director that the claim is in accordance with the State Employee

Indemnification Act and that they approve of the payment. In no event shall an amount in excess of $150,000 be paid from this plan to or for the benefit of any claimant.

(13) Administer a plan the purpose of which is to make payments on final settlements or final judgments for employee wage claims in situations where there was an appropriation relevant to the wage claim, the fiscal year and lapse period have expired, and sufficient funds were available to pay the claim. The plan shall be funded through appropriations from the General Revenue Fund specifically designated for that purpose.

Subject to sufficient appropriation, the Director is authorized to pay any wage claim presented to the Director that is supported by a final settlement or final judgment when the chief officer of the State agency employing the claimant certifies to the Director that the claim is a valid wage claim and that the fiscal year and lapse period have expired. Payment for claims that are properly submitted and certified as valid by the Director shall include interest accrued at the rate of 7% per annum from the forty-fifth day after the claims are received by the Department or 45 days from the date on which the amount of payment is agreed upon, whichever is later, until the date the claims are submitted to the Comptroller for payment. When the Attorney General has filed an appearance in any proceeding concerning a wage claim settlement or judgment,

the Attorney General shall certify to the Director that the wage claim is valid before any payment is made. In no event shall an amount in excess of $150,000 be paid from this plan to or for the benefit of any claimant.

Nothing in Public Act 84-961 shall be construed to affect in any manner the jurisdiction of the Court of Claims concerning wage claims made against the State of Illinois.

(14) Prepare and, in the discretion of the Director, implement a program for self-insurance for official fidelity and surety bonds for officers and employees as authorized by the Official Bond Act.

(Source: P.A. 96-928, eff. 6-15-10.)

(20 ILCS 405/405-411)

Sec. 405-411. Consolidation of workers' compensation functions.

(a) Notwithstanding any other law to the contrary, the Director of Central Management Services, working in cooperation with the Director of any other agency, department, board, or commission directly responsible to the Governor, may direct the consolidation, within the Department of Central Management Services, of those workers' compensation functions at that agency, department, board, or commission that are suitable for centralization.

Upon receipt of the written direction to transfer workers'

compensation functions to the Department of Central Management Services, the personnel, equipment, and property (both real and personal) directly relating to the transferred functions shall be transferred to the Department of Central Management Services, and the relevant documents, records, and correspondence shall be transferred or copied, as the Director may prescribe.

(b) Upon receiving written direction from the Director of Central Management Services, the Comptroller and Treasurer are authorized to transfer the unexpended balance of any appropriations related to the workers' compensation functions transferred to the Department of Central Management Services and shall make the necessary fund transfers from the General Revenue Fund, any special fund in the State treasury, or any other federal or State trust fund held by the Treasurer to the Workers' Compensation Revolving Fund for use by the Department of Central Management Services in support of workers' compensation functions or any other related costs or expenses of the Department of Central Management Services.

(c) The rights of employees and the State and its agencies under the Personnel Code and applicable collective bargaining agreements or under any pension, retirement, or annuity plan shall not be affected by any transfer under this Section.

(d) The functions transferred to the Department of Central Management Services by this Section shall be vested in and shall be exercised by the Department of Central Management

Services. Each act done in the exercise of those functions shall have the same legal effect as if done by the agencies, offices, divisions, departments, bureaus, boards and commissions from which they were transferred.

Every person or other entity shall be subject to the same obligations and duties and any penalties, civil or criminal, arising therefrom, and shall have the same rights arising from the exercise of such rights, powers, and duties as had been exercised by the agencies, offices, divisions, departments, bureaus, boards, and commissions from which they were transferred.

Whenever reports or notices are now required to be made or given or papers or documents furnished or served by any person in regards to the functions transferred to or upon the agencies, offices, divisions, departments, bureaus, boards, and commissions from which the functions were transferred, the same shall be made, given, furnished or served in the same manner to or upon the Department of Central Management Services.

This Section does not affect any act done, ratified, or cancelled or any right occurring or established or any action or proceeding had or commenced in an administrative, civil, or criminal cause regarding the functions transferred, but those proceedings may be continued by the Department of Central Management Services.

This Section does not affect the legality of any rules in

the Illinois Administrative Code regarding the functions transferred in this Section that are in force on the effective date of this Section. If necessary, however, the affected agencies shall propose, adopt, or repeal rules, rule amendments, and rule recodifications as appropriate to effectuate this Section.

(e) There is hereby created within the Department of Central Management Services an advisory body to be known as the State Workers' Compensation Program Advisory Board to review, assess, and provide recommendations to improve the State workers' compensation program and to ensure that the State manages the program in the interests of injured workers and taxpayers. The Governor shall appoint one person to the Board, who shall serve as the Chairperson. The Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate shall each appoint one person to the Board. Each member initially appointed to the Board shall serve a term ending December 31, 2013, and each Board member appointed thereafter shall serve a 3-year term. A Board member shall continue to serve on the Board until his or her successor is appointed. In addition, the Director of the Department of Central Management Services, the Attorney General, the Director of the Department of Insurance, the Secretary of the Department of Transportation, the Director of the Department of Corrections, the Secretary of the Department of Human Services,

the Director of the Department of Revenue, and the Chairman of the Illinois Workers' Compensation Commission, or their designees, shall serve as ex officio, non-voting members of the Board. Members of the Board shall not receive compensation but shall be reimbursed from the Workers' Compensation Revolving Fund for reasonable expenses incurred in the necessary performance of their duties, and the Department of Central Management Services shall provide administrative support to the Board. The Board shall meet at least 3 times per year or more often if the Board deems it necessary or proper. By September 30, 2011, the Board shall issue a written report, to be delivered to the Governor, the Director of the Department of Central Management Services, and the General Assembly, with a recommended set of best practices for the State workers' compensation program. By July 1 of each year thereafter, the Board shall issue a written report, to be delivered to those same persons or entities, with recommendations on how to improve upon such practices.

(Source: P.A. 93-839, eff. 7-30-04.)

Section 10. The Code of Civil Procedure is amended by changing Section 8-802 as follows:

(735 ILCS 5/8-802) (from Ch. 110, par. 8-802)

Sec. 8-802. Physician and patient. No physician or surgeon shall be permitted to disclose any information he or she may

have acquired in attending any patient in a professional character, necessary to enable him or her professionally to serve the patient, except only (1) in trials for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide, (2) in actions, civil or criminal, against the physician for malpractice, (3) with the expressed consent of the patient, or in case of his or her death or disability, of his or her personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his or her life, health, or physical condition, (4) in all actions brought by or against the patient, his or her personal representative, a beneficiary under a policy of insurance, or the executor or administrator of his or her estate wherein the patient's physical or mental condition is an issue, (5) upon an issue as to the validity of a document as a will of the patient, (6) in any criminal action where the charge is either first degree murder by abortion, attempted abortion or abortion, (7) in actions, civil or criminal, arising from the filing of a report in compliance with the Abused and Neglected Child Reporting Act, (8) to any department, agency, institution or facility which has custody of the patient pursuant to State statute or any court order of commitment, (9) in prosecutions where written results of blood alcohol tests are admissible pursuant to Section 11-501.4 of the Illinois Vehicle Code, (10) in prosecutions where written results of blood alcohol tests are admissible under Section

5-11a of the Boat Registration and Safety Act, (11) in criminal actions arising from the filing of a report of suspected terrorist offense in compliance with Section 29D-10(p)(7) of the Criminal Code of 1961, or (12) upon the issuance of a subpoena pursuant to Section 38 of the Medical Practice Act of 1987; the issuance of a subpoena pursuant to Section 25.1 of the Illinois Dental Practice Act; ~~or~~ the issuance of a subpoena pursuant to Section 22 of the Nursing Home Administrators Licensing and Disciplinary Act; or the issuance of a subpoena pursuant to Section 25.5 of the Workers' Compensation Act.

In the event of a conflict between the application of this Section and the Mental Health and Developmental Disabilities Confidentiality Act to a specific situation, the provisions of the Mental Health and Developmental Disabilities Confidentiality Act shall control.

(Source: P.A. 95-478, eff. 8-27-07.)

Section 15. The Workers' Compensation Act is amended by changing Sections 1, 4, 8, 8.2, 8.7, 11, 13, 13.1, 14, 18, 19, and 25.5 and by adding Sections 1.1, 4b, 8.1a, 8.1b, 8.2a, 16b, 18.1, 29.1, and 29.2 as follows:

(820 ILCS 305/1) (from Ch. 48, par. 138.1)

Sec. 1. This Act may be cited as the Workers' Compensation Act.

(a) The term "employer" as used in this Act means:

1. The State and each county, city, town, township, incorporated village, school district, body politic, or municipal corporation therein.

2. Every person, firm, public or private corporation, including hospitals, public service, eleemosynary, religious or charitable corporations or associations who has any person in service or under any contract for hire, express or implied, oral or written, and who is engaged in any of the enterprises or businesses enumerated in Section 3 of this Act, or who at or prior to the time of the accident to the employee for which compensation under this Act may be claimed, has in the manner provided in this Act elected to become subject to the provisions of this Act, and who has not, prior to such accident, effected a withdrawal of such election in the manner provided in this Act.

3. Any one engaging in any business or enterprise referred to in subsections 1 and 2 of Section 3 of this Act who undertakes to do any work enumerated therein, is liable to pay compensation to his own immediate employees in accordance with the provisions of this Act, and in addition thereto if he directly or indirectly engages any contractor whether principal or sub-contractor to do any such work, he is liable to pay compensation to the employees of any such contractor or sub-contractor unless such contractor or sub-contractor has insured, in any company or association authorized under the laws of this State to insure the liability to pay compensation

under this Act, or guaranteed his liability to pay such compensation. With respect to any time limitation on the filing of claims provided by this Act, the timely filing of a claim against a contractor or subcontractor, as the case may be, shall be deemed to be a timely filing with respect to all persons upon whom liability is imposed by this paragraph.

In the event any such person pays compensation under this subsection he may recover the amount thereof from the contractor or sub-contractor, if any, and in the event the contractor pays compensation under this subsection he may recover the amount thereof from the sub-contractor, if any.

This subsection does not apply in any case where the accident occurs elsewhere than on, in or about the immediate premises on which the principal has contracted that the work be done.

4. Where an employer operating under and subject to the provisions of this Act loans an employee to another such employer and such loaned employee sustains a compensable accidental injury in the employment of such borrowing employer and where such borrowing employer does not provide or pay the benefits or payments due such injured employee, such loaning employer is liable to provide or pay all benefits or payments due such employee under this Act and as to such employee the liability of such loaning and borrowing employers is joint and several, provided that such loaning employer is in the absence of agreement to the contrary entitled to receive from such

borrowing employer full reimbursement for all sums paid or incurred pursuant to this paragraph together with reasonable attorneys' fees and expenses in any hearings before the Illinois Workers' Compensation Commission or in any action to secure such reimbursement. Where any benefit is provided or paid by such loaning employer the employee has the duty of rendering reasonable cooperation in any hearings, trials or proceedings in the case, including such proceedings for reimbursement.

Where an employee files an Application for Adjustment of Claim with the Illinois Workers' Compensation Commission alleging that his claim is covered by the provisions of the preceding paragraph, and joining both the alleged loaning and borrowing employers, they and each of them, upon written demand by the employee and within 7 days after receipt of such demand, shall have the duty of filing with the Illinois Workers' Compensation Commission a written admission or denial of the allegation that the claim is covered by the provisions of the preceding paragraph and in default of such filing or if any such denial be ultimately determined not to have been bona fide then the provisions of Paragraph K of Section 19 of this Act shall apply.

An employer whose business or enterprise or a substantial part thereof consists of hiring, procuring or furnishing employees to or for other employers operating under and subject to the provisions of this Act for the performance of the work

of such other employers and who pays such employees their salary or wages notwithstanding that they are doing the work of such other employers shall be deemed a loaning employer within the meaning and provisions of this Section.

(b) The term "employee" as used in this Act means:

1. Every person in the service of the State, including members of the General Assembly, members of the Commerce Commission, members of the Illinois Workers' Compensation Commission, and all persons in the service of the University of Illinois, county, including deputy sheriffs and assistant state's attorneys, city, town, township, incorporated village or school district, body politic, or municipal corporation therein, whether by election, under appointment or contract of hire, express or implied, oral or written, including all members of the Illinois National Guard while on active duty in the service of the State, and all probation personnel of the Juvenile Court appointed pursuant to Article VI of the Juvenile Court Act of 1987, and including any official of the State, any county, city, town, township, incorporated village, school district, body politic or municipal corporation therein except any duly appointed member of a police department in any city whose population exceeds 200,000 according to the last Federal or State census, and except any member of a fire insurance patrol maintained by a board of underwriters in this State. A duly appointed member of a fire department in any city, the population of which exceeds 200,000 according to the last

federal or State census, is an employee under this Act only with respect to claims brought under paragraph (c) of Section 8.

One employed by a contractor who has contracted with the State, or a county, city, town, township, incorporated village, school district, body politic or municipal corporation therein, through its representatives, is not considered as an employee of the State, county, city, town, township, incorporated village, school district, body politic or municipal corporation which made the contract.

2. Every person in the service of another under any contract of hire, express or implied, oral or written, including persons whose employment is outside of the State of Illinois where the contract of hire is made within the State of Illinois, persons whose employment results in fatal or non-fatal injuries within the State of Illinois where the contract of hire is made outside of the State of Illinois, and persons whose employment is principally localized within the State of Illinois, regardless of the place of the accident or the place where the contract of hire was made, and including aliens, and minors who, for the purpose of this Act are considered the same and have the same power to contract, receive payments and give quittances therefor, as adult employees.

3. Every sole proprietor and every partner of a business may elect to be covered by this Act.

An employee or his dependents under this Act who shall have a cause of action by reason of any injury, disablement or death arising out of and in the course of his employment may elect to pursue his remedy in the State where injured or disabled, or in the State where the contract of hire is made, or in the State where the employment is principally localized.

However, any employer may elect to provide and pay compensation to any employee other than those engaged in the usual course of the trade, business, profession or occupation of the employer by complying with Sections 2 and 4 of this Act. Employees are not included within the provisions of this Act when excluded by the laws of the United States relating to liability of employers to their employees for personal injuries where such laws are held to be exclusive.

The term "employee" does not include persons performing services as real estate broker, broker-salesman, or salesman when such persons are paid by commission only.

(c) "Commission" means the Industrial Commission created by Section 5 of "The Civil Administrative Code of Illinois", approved March 7, 1917, as amended, or the Illinois Workers' Compensation Commission created by Section 13 of this Act.

(d) To obtain compensation under this Act, an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment.

(Source: P.A. 93-721, eff. 1-1-05.)

(820 ILCS 305/1.1 new)

Sec. 1.1. Standards of conduct.

(a) Commissioners and arbitrators shall dispose of all Workers' Compensation matters promptly, officially and fairly, without bias or prejudice. Commissioners and arbitrators shall be faithful to the law and maintain professional competence in it. They shall be unswayed by partisan interests, public clamor, or fear of criticism. Commissioners and arbitrators shall take appropriate action or initiate appropriate disciplinary measures against a Commissioner, arbitrator, lawyer, or others for unprofessional conduct of which the Commissioner or arbitrator may become aware.

(b) Except as otherwise provided in this Act, the Canons of the Code of Judicial Conduct as adopted by the Supreme Court of Illinois govern the hearing and non-hearing conduct of members of the Commission and arbitrators under this Act. The Commission may set additional rules and standards, not less stringent than those rules and standards established by the Code of Judicial Conduct, for the conduct of arbitrators.

(c) The following provisions of the Code of Judicial Conduct do not apply under this Section:

(1) Canon 3(B), relating to administrative responsibilities of Judges.

(2) Canon 6(C), relating to annual filings of economic interests. Instead of filing declarations of economic

interests with the Clerk of the Illinois Supreme Court under Illinois Supreme Court Rule 68, members of the Commission and arbitrators shall make filings substantially similar to those required by Rule 68 with the Chairman, and such filings shall be made available for examination by the public.

(d) An arbitrator or a Commissioner may accept an uncompensated appointment to a governmental committee, commission or other position that is concerned with issues of policy on matters which may come before the arbitrator or Commissioner if such appointment neither affects his or her independent professional judgment nor the conduct of his or her duties.

(e) Decisions of an arbitrator or a Commissioner shall be based exclusively on evidence in the record of the proceeding and material that has been officially noticed. Any findings of fact made by the arbitrator based on inquiries, investigations, examinations, or inspections undertaken by the arbitrator shall be entered into the record of the proceeding.

(f) Nothing in this Section shall prohibit an arbitrator from holding a pre-trial conference in accordance with the rules of the Commission.

(820 ILCS 305/4) (from Ch. 48, par. 138.4)

Sec. 4. (a) Any employer, including but not limited to general contractors and their subcontractors, who shall come

within the provisions of Section 3 of this Act, and any other employer who shall elect to provide and pay the compensation provided for in this Act shall:

(1) File with the Commission annually an application for approval as a self-insurer which shall include a current financial statement, and annually, thereafter, an application for renewal of self-insurance, which shall include a current financial statement. Said application and financial statement shall be signed and sworn to by the president or vice president and secretary or assistant secretary of the employer if it be a corporation, or by all of the partners, if it be a copartnership, or by the owner if it be neither a copartnership nor a corporation. All initial applications and all applications for renewal of self-insurance must be submitted at least 60 days prior to the requested effective date of self-insurance. An employer may elect to provide and pay compensation as provided for in this Act as a member of a group workers' compensation pool under Article V 3/4 of the Illinois Insurance Code. If an employer becomes a member of a group workers' compensation pool, the employer shall not be relieved of any obligations imposed by this Act.

If the sworn application and financial statement of any such employer does not satisfy the Commission of the financial ability of the employer who has filed it, the Commission shall require such employer to,

(2) Furnish security, indemnity or a bond guaranteeing the payment by the employer of the compensation provided for in this Act, provided that any such employer whose application and financial statement shall not have satisfied the commission of his or her financial ability and who shall have secured his liability in part by excess liability insurance shall be required to furnish to the Commission security, indemnity or bond guaranteeing his or her payment up to the effective limits of the excess coverage, or

(3) Insure his entire liability to pay such compensation in some insurance carrier authorized, licensed, or permitted to do such insurance business in this State. Every policy of an insurance carrier, insuring the payment of compensation under this Act shall cover all the employees and the entire compensation liability of the insured: Provided, however, that any employer may insure his or her compensation liability with 2 or more insurance carriers or may insure a part and qualify under subsection 1, 2, or 4 for the remainder of his or her liability to pay such compensation, subject to the following two provisions:

Firstly, the entire compensation liability of the employer to employees working at or from one location shall be insured in one such insurance carrier or shall be self-insured, and

Secondly, the employer shall submit evidence satisfactorily to the Commission that his or her entire liability for the compensation provided for in this Act will be secured. Any provisions in any policy, or in any endorsement attached thereto, attempting to limit or modify in any way, the liability of the insurance carriers issuing the same except as otherwise provided herein shall be wholly void.

Nothing herein contained shall apply to policies of excess liability carriage secured by employers who have been approved by the Commission as self-insurers, or

(4) Make some other provision, satisfactory to the Commission, for the securing of the payment of compensation provided for in this Act, and

(5) Upon becoming subject to this Act and thereafter as often as the Commission may in writing demand, file with the Commission in form prescribed by it evidence of his or her compliance with the provision of this Section.

(a-1) Regardless of its state of domicile or its principal place of business, an employer shall make payments to its insurance carrier or group self-insurance fund, where applicable, based upon the premium rates of the situs where the work or project is located in Illinois if:

(A) the employer is engaged primarily in the building and construction industry; and

(B) subdivision (a)(3) of this Section applies to the

employer or the employer is a member of a group self-insurance plan as defined in subsection (1) of Section 4a.

The Illinois Workers' Compensation Commission shall impose a penalty upon an employer for violation of this subsection (a-1) if:

(i) the employer is given an opportunity at a hearing to present evidence of its compliance with this subsection (a-1); and

(ii) after the hearing, the Commission finds that the employer failed to make payments upon the premium rates of the situs where the work or project is located in Illinois.

The penalty shall not exceed $1,000 for each day of work for which the employer failed to make payments upon the premium rates of the situs where the work or project is located in Illinois, but the total penalty shall not exceed $50,000 for each project or each contract under which the work was performed.

Any penalty under this subsection (a-1) must be imposed not later than one year after the expiration of the applicable limitation period specified in subsection (d) of Section 6 of this Act. Penalties imposed under this subsection (a-1) shall be deposited into the Illinois Workers' Compensation Commission Operations Fund, a special fund that is created in the State treasury. Subject to appropriation, moneys in the Fund shall be used solely for the operations of the Illinois

Workers' Compensation Commission and by the Department of Insurance ~~Financial and Professional Regulation~~ for the purposes authorized in subsection (c) of Section 25.5 of this Act.

(a-2) Every Employee Leasing Company (ELC), as defined in Section 15 of the Employee Leasing Company Act, shall at a minimum provide the following information to the Commission or any entity designated by the Commission regarding each workers' compensation insurance policy issued to the ELC:

(1) Any client company of the ELC listed as an additional named insured.

(2) Any informational schedule attached to the master policy that identifies any individual client company's name, FEIN, and job location.

(3) Any certificate of insurance coverage document issued to a client company specifying its rights and obligations under the master policy that establishes both the identity and status of the client, as well as the dates of inception and termination of coverage, if applicable.

(b) The sworn application and financial statement, or security, indemnity or bond, or amount of insurance, or other provisions, filed, furnished, carried, or made by the employer, as the case may be, shall be subject to the approval of the Commission.

Deposits under escrow agreements shall be cash, negotiable United States government bonds or negotiable general

obligation bonds of the State of Illinois. Such cash or bonds shall be deposited in escrow with any State or National Bank or Trust Company having trust authority in the State of Illinois.

Upon the approval of the sworn application and financial statement, security, indemnity or bond or amount of insurance, filed, furnished or carried, as the case may be, the Commission shall send to the employer written notice of its approval thereof. The certificate of compliance by the employer with the provisions of subparagraphs (2) and (3) of paragraph (a) of this Section shall be delivered by the insurance carrier to the Illinois Workers' Compensation Commission within five days after the effective date of the policy so certified. The insurance so certified shall cover all compensation liability occurring during the time that the insurance is in effect and no further certificate need be filed in case such insurance is renewed, extended or otherwise continued by such carrier. The insurance so certified shall not be cancelled or in the event that such insurance is not renewed, extended or otherwise continued, such insurance shall not be terminated until at least 10 days after receipt by the Illinois Workers' Compensation Commission of notice of the cancellation or termination of said insurance; provided, however, that if the employer has secured insurance from another insurance carrier, or has otherwise secured the payment of compensation in accordance with this Section, and such insurance or other security becomes effective prior to the expiration of the 10

days, cancellation or termination may, at the option of the insurance carrier indicated in such notice, be effective as of the effective date of such other insurance or security.

(c) Whenever the Commission shall find that any corporation, company, association, aggregation of individuals, reciprocal or interinsurers exchange, or other insurer effecting workers' compensation insurance in this State shall be insolvent, financially unsound, or unable to fully meet all payments and liabilities assumed or to be assumed for compensation insurance in this State, or shall practice a policy of delay or unfairness toward employees in the adjustment, settlement, or payment of benefits due such employees, the Commission may after reasonable notice and hearing order and direct that such corporation, company, association, aggregation of individuals, reciprocal or interinsurers exchange, or insurer, shall from and after a date fixed in such order discontinue the writing of any such workers' compensation insurance in this State. Subject to such modification of the order as the Commission may later make on review of the order, as herein provided, it shall thereupon be unlawful for any such corporation, company, association, aggregation of individuals, reciprocal or interinsurers exchange, or insurer to effect any workers' compensation insurance in this State. A copy of the order shall be served upon the Director of Insurance by registered mail. Whenever the Commission finds that any service or adjustment company used or

employed by a self-insured employer or by an insurance carrier to process, adjust, investigate, compromise or otherwise handle claims under this Act, has practiced or is practicing a policy of delay or unfairness toward employees in the adjustment, settlement or payment of benefits due such employees, the Commission may after reasonable notice and hearing order and direct that such service or adjustment company shall from and after a date fixed in such order be prohibited from processing, adjusting, investigating, compromising or otherwise handling claims under this Act.

Whenever the Commission finds that any self-insured employer has practiced or is practicing delay or unfairness toward employees in the adjustment, settlement or payment of benefits due such employees, the Commission may, after reasonable notice and hearing, order and direct that after a date fixed in the order such self-insured employer shall be disqualified to operate as a self-insurer and shall be required to insure his entire liability to pay compensation in some insurance carrier authorized, licensed and permitted to do such insurance business in this State, as provided in subparagraph 3 of paragraph (a) of this Section.

All orders made by the Commission under this Section shall be subject to review by the courts, said review to be taken in the same manner and within the same time as provided by Section 19 of this Act for review of awards and decisions of the Commission, upon the party seeking the review filing with the

clerk of the court to which said review is taken a bond in an amount to be fixed and approved by the court to which the review is taken, conditioned upon the payment of all compensation awarded against the person taking said review pending a decision thereof and further conditioned upon such other obligations as the court may impose. Upon the review the Circuit Court shall have power to review all questions of fact as well as of law. The penalty hereinafter provided for in this paragraph shall not attach and shall not begin to run until the final determination of the order of the Commission.

(d) Whenever a panel of 3 Commissioners comprised of one member of the employing class, one member of the employee class, and one member not identified with either the employing or employee class, with due process and after a hearing, determines an employer has knowingly failed to provide coverage as required by paragraph (a) of this Section, the failure shall be deemed an immediate serious danger to public health, safety, and welfare sufficient to justify service by the Commission of a work-stop order on such employer, requiring the cessation of all business operations of such employer at the place of employment or job site. Any law enforcement agency in the State shall, at the request of the Commission, render any assistance necessary to carry out the provisions of this Section, including, but not limited to, preventing any employee of such employer from remaining at a place of employment or job site after a work-stop order has taken effect. Any work-stop order

shall be lifted upon proof of insurance as required by this Act. Any orders under this Section are appealable under Section 19(f) to the Circuit Court.

Any individual employer, corporate officer or director of a corporate employer, partner of an employer partnership, or member of an employer limited liability company who knowingly fails to provide coverage as required by paragraph (a) of this Section is guilty of a Class 4 felony. This provision shall not apply to any corporate officer or director of any publicly-owned corporation. Each day's violation constitutes a separate offense. The State's Attorney of the county in which the violation occurred, or the Attorney General, shall bring such actions in the name of the People of the State of Illinois, or may, in addition to other remedies provided in this Section, bring an action for an injunction to restrain the violation or to enjoin the operation of any such employer.

Any individual employer, corporate officer or director of a corporate employer, partner of an employer partnership, or member of an employer limited liability company who negligently fails to provide coverage as required by paragraph (a) of this Section is guilty of a Class A misdemeanor. This provision shall not apply to any corporate officer or director of any publicly-owned corporation. Each day's violation constitutes a separate offense. The State's Attorney of the county in which the violation occurred, or the Attorney General, shall bring such actions in the name of the People of the State of

Illinois.

The criminal penalties in this subsection (d) shall not apply where there exists a good faith dispute as to the existence of an employment relationship. Evidence of good faith shall include, but not be limited to, compliance with the definition of employee as used by the Internal Revenue Service.

Employers who are subject to and who knowingly fail to comply with this Section shall not be entitled to the benefits of this Act during the period of noncompliance, but shall be liable in an action under any other applicable law of this State. In the action, such employer shall not avail himself or herself of the defenses of assumption of risk or negligence or that the injury was due to a co-employee. In the action, proof of the injury shall constitute prima facie evidence of negligence on the part of such employer and the burden shall be on such employer to show freedom of negligence resulting in the injury. The employer shall not join any other defendant in any such civil action. Nothing in this amendatory Act of the 94th General Assembly shall affect the employee's rights under subdivision (a)3 of Section 1 of this Act. Any employer or carrier who makes payments under subdivision (a)3 of Section 1 of this Act shall have a right of reimbursement from the proceeds of any recovery under this Section.

An employee of an uninsured employer, or the employee's dependents in case death ensued, may, instead of proceeding against the employer in a civil action in court, file an

application for adjustment of claim with the Commission in accordance with the provisions of this Act and the Commission shall hear and determine the application for adjustment of claim in the manner in which other claims are heard and determined before the Commission.

All proceedings under this subsection (d) shall be reported on an annual basis to the Workers' Compensation Advisory Board.

An investigator with the Illinois Workers' Compensation Commission Insurance Compliance Division may issue a citation to any employer that is not in compliance with its obligation to have workers' compensation insurance under this Act. The amount of the fine shall be based on the period of time the employer was in non-compliance, but shall be no less than $500, and shall not exceed $2,500. An employer that has been issued a citation shall pay the fine to the Commission and provide to the Commission proof that it obtained the required workers' compensation insurance within 10 days after the citation was issued. This Section does not affect any other obligations this Act imposes on employers.

Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and wilful failure or refusal of an employer to comply with any of the provisions of paragraph (a) of this Section, ~~or~~ the failure or refusal of an employer, service or adjustment company, or an insurance carrier to comply with any order of the Illinois Workers' Compensation Commission pursuant to paragraph (c) of this Section

disqualifying him or her to operate as a self insurer and requiring him or her to insure his or her liability, or the knowing and willful failure of an employer to comply with a citation issued by an investigator with the Illinois Workers' Compensation Commission Insurance Compliance Division, the Commission may assess a civil penalty of up to $500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of $10,000. Each day of such failure or refusal shall constitute a separate offense. The Commission may assess the civil penalty personally and individually against the corporate officers and directors of a corporate employer, the partners of an employer partnership, and the members of an employer limited liability company, after a finding of a knowing and willful refusal or failure of each such named corporate officer, director, partner, or member to comply with this Section. The liability for the assessed penalty shall be against the named employer first, and if the named employer fails or refuses to pay the penalty to the Commission within 30 days after the final order of the Commission, then the named corporate officers, directors, partners, or members who have been found to have knowingly and willfully refused or failed to comply with this Section shall be liable for the unpaid penalty or any unpaid portion of the penalty. Upon investigation by the insurance non-compliance unit of the Commission, the Attorney General shall have the

authority to prosecute all proceedings to enforce the civil and administrative provisions of this Section before the Commission. The Commission shall promulgate procedural rules for enforcing this Section.

Upon the failure or refusal of any employer, service or adjustment company or insurance carrier to comply with the provisions of this Section and with the orders of the Commission under this Section, or the order of the court on review after final adjudication, the Commission may bring a civil action to recover the amount of the penalty in Cook County or in Sangamon County in which litigation the Commission shall be represented by the Attorney General. The Commission shall send notice of its finding of non-compliance and assessment of the civil penalty to the Attorney General. It shall be the duty of the Attorney General within 30 days after receipt of the notice, to institute prosecutions and promptly prosecute all reported violations of this Section.

Any individual employer, corporate officer or director of a corporate employer, partner of an employer partnership, or member of an employer limited liability company who, with the intent to avoid payment of compensation under this Act to an injured employee or the employee's dependents, knowingly transfers, sells, encumbers, assigns, or in any manner disposes of, conceals, secretes, or destroys any property belonging to the employer, officer, director, partner, or member is guilty of a Class 4 felony.

Penalties and fines collected pursuant to this paragraph (d) shall be deposited upon receipt into a special fund which shall be designated the Injured Workers' Benefit Fund, of which the State Treasurer is ex-officio custodian, such special fund to be held and disbursed in accordance with this paragraph (d) for the purposes hereinafter stated in this paragraph (d), upon the final order of the Commission. The Injured Workers' Benefit Fund shall be deposited the same as are State funds and any interest accruing thereon shall be added thereto every 6 months. The Injured Workers' Benefit Fund is subject to audit the same as State funds and accounts and is protected by the general bond given by the State Treasurer. The Injured Workers' Benefit Fund is considered always appropriated for the purposes of disbursements as provided in this paragraph, and shall be paid out and disbursed as herein provided and shall not at any time be appropriated or diverted to any other use or purpose. Moneys in the Injured Workers' Benefit Fund shall be used only for payment of workers' compensation benefits for injured employees when the employer has failed to provide coverage as determined under this paragraph (d) and has failed to pay the benefits due to the injured employee. The Commission shall have the right to obtain reimbursement from the employer for compensation obligations paid by the Injured Workers' Benefit Fund. Any such amounts obtained shall be deposited by the Commission into the Injured Workers' Benefit Fund. If an injured employee or his or her personal representative receives

payment from the Injured Workers' Benefit Fund, the State of Illinois has the same rights under paragraph (b) of Section 5 that the employer who failed to pay the benefits due to the injured employee would have had if the employer had paid those benefits, and any moneys recovered by the State as a result of the State's exercise of its rights under paragraph (b) of Section 5 shall be deposited into the Injured Workers' Benefit Fund. The custodian of the Injured Workers' Benefit Fund shall be joined with the employer as a party respondent in the application for adjustment of claim. After July 1, 2006, the Commission shall make disbursements from the Fund once each year to each eligible claimant. An eligible claimant is an injured worker who has within the previous fiscal year obtained a final award for benefits from the Commission against the employer and the Injured Workers' Benefit Fund and has notified the Commission within 90 days of receipt of such award. Within a reasonable time after the end of each fiscal year, the Commission shall make a disbursement to each eligible claimant. At the time of disbursement, if there are insufficient moneys in the Fund to pay all claims, each eligible claimant shall receive a pro-rata share, as determined by the Commission, of the available moneys in the Fund for that year. Payment from the Injured Workers' Benefit Fund to an eligible claimant pursuant to this provision shall discharge the obligations of the Injured Workers' Benefit Fund regarding the award entered by the Commission.

(e) This Act shall not affect or disturb the continuance of any existing insurance, mutual aid, benefit, or relief association or department, whether maintained in whole or in part by the employer or whether maintained by the employees, the payment of benefits of such association or department being guaranteed by the employer or by some person, firm or corporation for him or her: Provided, the employer contributes to such association or department an amount not less than the full compensation herein provided, exclusive of the cost of the maintenance of such association or department and without any expense to the employee. This Act shall not prevent the organization and maintaining under the insurance laws of this State of any benefit or insurance company for the purpose of insuring against the compensation provided for in this Act, the expense of which is maintained by the employer. This Act shall not prevent the organization or maintaining under the insurance laws of this State of any voluntary mutual aid, benefit or relief association among employees for the payment of additional accident or sick benefits.

(f) No existing insurance, mutual aid, benefit or relief association or department shall, by reason of anything herein contained, be authorized to discontinue its operation without first discharging its obligations to any and all persons carrying insurance in the same or entitled to relief or benefits therein.

(g) Any contract, oral, written or implied, of employment

providing for relief benefit, or insurance or any other device whereby the employee is required to pay any premium or premiums for insurance against the compensation provided for in this Act shall be null and void. Any employer withholding from the wages of any employee any amount for the purpose of paying any such premium shall be guilty of a Class B misdemeanor.

In the event the employer does not pay the compensation for which he or she is liable, then an insurance company, association or insurer which may have insured such employer against such liability shall become primarily liable to pay to the employee, his or her personal representative or beneficiary the compensation required by the provisions of this Act to be paid by such employer. The insurance carrier may be made a party to the proceedings in which the employer is a party and an award may be entered jointly against the employer and the insurance carrier.

(h) It shall be unlawful for any employer, insurance company or service or adjustment company to interfere with, restrain or coerce an employee in any manner whatsoever in the exercise of the rights or remedies granted to him or her by this Act or to discriminate, attempt to discriminate, or threaten to discriminate against an employee in any way because of his or her exercise of the rights or remedies granted to him or her by this Act.

It shall be unlawful for any employer, individually or through any insurance company or service or adjustment company,

to discharge or to threaten to discharge, or to refuse to rehire or recall to active service in a suitable capacity an employee because of the exercise of his or her rights or remedies granted to him or her by this Act.

(i) If an employer elects to obtain a life insurance policy on his employees, he may also elect to apply such benefits in satisfaction of all or a portion of the death benefits payable under this Act, in which case, the employer's compensation premium shall be reduced accordingly.

(j) Within 45 days of receipt of an initial application or application to renew self-insurance privileges the Self-Insurers Advisory Board shall review and submit for approval by the Chairman of the Commission recommendations of disposition of all initial applications to self-insure and all applications to renew self-insurance privileges filed by private self-insurers pursuant to the provisions of this Section and Section 4a-9 of this Act. Each private self-insurer shall submit with its initial and renewal applications the application fee required by Section 4a-4 of this Act.

The Chairman of the Commission shall promptly act upon all initial applications and applications for renewal in full accordance with the recommendations of the Board or, should the Chairman disagree with any recommendation of disposition of the Self-Insurer's Advisory Board, he shall within 30 days of receipt of such recommendation provide to the Board in writing the reasons supporting his decision. The Chairman shall also

promptly notify the employer of his decision within 15 days of receipt of the recommendation of the Board.

If an employer is denied a renewal of self-insurance privileges pursuant to application it shall retain said privilege for 120 days after receipt of a notice of cancellation of the privilege from the Chairman of the Commission.

All orders made by the Chairman under this Section shall be subject to review by the courts, such review to be taken in the same manner and within the same time as provided by subsection (f) of Section 19 of this Act for review of awards and decisions of the Commission, upon the party seeking the review filing with the clerk of the court to which such review is taken a bond in an amount to be fixed and approved by the court to which the review is taken, conditioned upon the payment of all compensation awarded against the person taking such review pending a decision thereof and further conditioned upon such other obligations as the court may impose. Upon the review the Circuit Court shall have power to review all questions of fact as well as of law.

(Source: P.A. 93-721, eff. 1-1-05; 94-277, eff. 7-20-05; 94-839, eff. 6-6-06.)

(820 ILCS 305/4b new)

Sec. 4b. Collective bargaining pilot program.

(a) The Director of the Department of Labor shall adopt a

selection process to designate 2 international, national, or statewide organizations made up of affiliates who are the exclusive representatives of construction employer employees recognized or certified pursuant to the National Labor Relations Act to participate in the collective bargaining pilot program provided for in this Section.

(a-5) For purposes of this Section, the term "construction employer" means any person or legal entity or group of persons or legal entities engaging in or planning to engage in any constructing, altering, reconstructing, repairing, rehabilitating, refinishing, refurbishing, remodeling, remediating, renovating, custom fabricating, maintaining, landscaping, improving, wrecking, painting, decorating, demolishing, and adding to or subtracting from any building, structure, airport facility, highway, roadway, street, alley, bridge, sewer, drain, ditch, sewage disposal plant, water works, parking facility, railroad, excavation or other project, structure, development, real property or improvement, or to do any part thereof, whether or not the performance of the work herein described involves the addition to, or fabrication into, any project, structure, development, real property or improvement herein described, and shall also include any moving of construction-related materials on the job site or to or from the job site.

For purposes of this Section, "labor organization" means an affiliate of an international, national, or statewide

organization that has been selected by the Department of Labor to participate in the collective bargaining pilot program as provided for in this Section.

(b) Upon appropriate filing, the Commission and the courts of this State shall recognize as valid and binding any provision in a collective bargaining agreement between any construction employer or group of construction employers and a labor organization, which contains certain obligations and procedures relating to workers' compensation. This agreement must be limited to, but need not include, all of the following:

(1) An alternative dispute resolution ("ADR") system to supplement, modify or replace the procedural or dispute resolution provisions of this Act. The system may include mediation, arbitration, or other dispute resolution proceedings, the results of which shall be final and binding upon the parties;

(2) An agreed list of medical treatment providers that may be the exclusive source of all medical and related treatment provided under this Act;

(3) The use of a limited list of impartial physicians to conduct independent medical examinations;

(4) The creation of a light duty, modified job, or return to work program;

(5) The use of a limited list of individuals and companies for the establishment of vocational rehabilitation or retraining programs that may be the

exclusive source of rehabilitation and retraining services provided under this Act; or

(6) The establishment of joint labor management safety committees and safety procedures.

(c) Void agreements. Nothing in this Section shall be construed to authorize any provision in a collective bargaining agreement that diminishes or increases a construction employer's entitlements under this Act or an employee's entitlement to benefits as otherwise set forth in this Act. For the purposes of this Section, the procedural rights and dispute resolution agreements under subparagraphs (1) through (6) of subsection (b) of this Section are not agreements which diminish or increase a construction employer's entitlements under this Act or an employee's entitlement to benefits under this Act. Any agreement that diminishes or increases a construction employer's entitlements under this Act or an employee's entitlement to benefits as set forth in this Act is null and void. Nothing in this Section shall be construed as creating a mandatory subject of bargaining.

(d) Form of agreement. The agreement reached herein shall demonstrate that:

(1) The construction employer or group of construction employers and the recognized or certified exclusive bargaining representative have entered into a binding collective bargaining agreement adopting the ADR plan for a period of no less than 2 years;

(2) Contractual agreements have been reached with the construction employer's workers' compensation carrier, group self-insurance fund, and any excess carriers relating to the ADR plan;

(3) Procedures have been established by which claims for benefits by employees will be lodged, administered, and decided while affording procedural due process;

(4) The plan has designated forms upon which claims for benefits shall be made;

(5) The system and means by which the construction employer's obligation to furnish medical services and vocational rehabilitation and retraining benefits shall be fulfilled and provider selected;

(6) The method by which mediators or arbitrators are to be selected.

(e) Filing. A copy of the agreement and a statement identifying the parties to the agreement shall be filed with the Commission. Within 21 days of receipt of an agreement, the Chairman shall review the agreement for compliance with this Section and notify the parties of its acceptance or notify the parties of any additional information required or any recommended modification that would bring the agreement into compliance. If no additional information or modification is required, the agreement shall be valid and binding from the time the parties receive acceptance of the agreement from the Chairman. Upon receipt of any requested information or

modification, the Chairman shall notify the parties within 21 days whether the agreement is in compliance with this Section. All rejections made by the Chairman under this subsection shall be subject to review by the courts of this State, said review to be taken in the same manner and within the same time as provided by Section 19 of this Act for review of awards and decisions of the Commission. Upon the review, the Circuit Court shall have power to review all questions of fact as well as of law.

(f) Notice to insurance carrier. If the construction employer is insured under this Act, it shall provide notice to and obtain consent from its insurance carrier, in the manner provided in the insurance contract, of its intent to enter into an agreement as provided in this Section with its employees.

(g) Employees' claims for workers' compensation benefits.

(1) Claims for benefits shall be filed with the ADR plan administrator within those periods of limitation prescribed by this Act. Within 10 days of the filing of a claim, the ADR plan administrator shall serve a copy of the claim application upon the Commission, which shall maintain records of all ADR claims and resolutions.

(2) Settlements of claims presented to the ADR plan administrator shall be evidenced by a settlement agreement. All such settlements shall be filed with the ADR plan administrator, who within 10 days shall forward a copy to the Commission for recording.

(3) Upon assignment of claims, unless settled, mediators and arbitrators shall render final orders containing essential findings of fact, rulings of law and referring to other matters as pertinent to the questions at issue. The ADR plan administrator shall maintain a record of the proceedings.

(h) Reporting requirements. Annually, each ADR plan administrator shall submit a report to the Commission containing the following information:

(1) The number of employees within the ADR program;

(2) The number of occurrences of work-related injuries or diseases;

(3) The breakdown within the ADR program of injuries and diseases treated;

(4) The total amount of disability benefits paid within the ADR program;

(5) The total medical treatment cost paid within the ADR program;

(6) The number of claims filed within the ADR program; and

(7) The disposition of all claims.

(820 ILCS 305/8) (from Ch. 48, par. 138.8)

Sec. 8. The amount of compensation which shall be paid to the employee for an accidental injury not resulting in death is:

(a) The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2, in effect at the time the service was rendered for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury, even if a health care provider sells, transfers, or otherwise assigns an account receivable for procedures, treatments, or services covered under this Act. If the employer does not dispute payment of first aid, medical, surgical, and hospital services, the employer shall make such payment to the provider on behalf of the employee. The employer shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto. If as a result of the injury the employee is unable to be self-sufficient the employer shall further pay for such maintenance or institutional care as shall be required.

The employee may at any time elect to secure his own physician, surgeon and hospital services at the employer's expense, or,

Upon agreement between the employer and the employees, or the employees' exclusive representative, and subject to the

approval of the Illinois Workers' Compensation Commission, the employer shall maintain a list of physicians, to be known as a Panel of Physicians, who are accessible to the employees. The employer shall post this list in a place or places easily accessible to his employees. The employee shall have the right to make an alternative choice of physician from such Panel if he is not satisfied with the physician first selected. If, due to the nature of the injury or its occurrence away from the employer's place of business, the employee is unable to make a selection from the Panel, the selection process from the Panel shall not apply. The physician selected from the Panel may arrange for any consultation, referral or other specialized medical services outside the Panel at the employer's expense. Provided that, in the event the Commission shall find that a doctor selected by the employee is rendering improper or inadequate care, the Commission may order the employee to select another doctor certified or qualified in the medical field for which treatment is required. If the employee refuses to make such change the Commission may relieve the employer of his obligation to pay the doctor's charges from the date of refusal to the date of compliance.

Any vocational rehabilitation counselors who provide service under this Act shall have appropriate certifications which designate the counselor as qualified to render opinions relating to vocational rehabilitation. Vocational rehabilitation may include, but is not limited to, counseling

for job searches, supervising a job search program, and vocational retraining including education at an accredited learning institution. The employee or employer may petition to the Commission to decide disputes relating to vocational rehabilitation and the Commission shall resolve any such dispute, including payment of the vocational rehabilitation program by the employer.

The maintenance benefit shall not be less than the temporary total disability rate determined for the employee. In addition, maintenance shall include costs and expenses incidental to the vocational rehabilitation program.

When the employee is working light duty on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs, then the employee shall be entitled to temporary partial disability benefits. Temporary partial disability benefits shall be equal to two-thirds of the difference between the average amount that the employee would be able to earn in the full performance of his or her duties in the occupation in which he or she was engaged at the time of accident and the gross ~~net~~ amount which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working.

Every hospital, physician, surgeon or other person rendering treatment or services in accordance with the provisions of this Section shall upon written request furnish

full and complete reports thereof to, and permit their records to be copied by, the employer, the employee or his dependents, as the case may be, or any other party to any proceeding for compensation before the Commission, or their attorneys.

Notwithstanding the foregoing, the employer's liability to pay for such medical services selected by the employee shall be limited to:

(1) all first aid and emergency treatment; plus

(2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical services in the chain of referrals from said initial service provider; plus

(3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second service provider. Thereafter the employer shall select and pay for all necessary medical, surgical and hospital treatment and the employee may not select a provider of medical services at the employer's expense unless the employer agrees to such

selection. At any time the employee may obtain any medical treatment he desires at his own expense. This paragraph shall not affect the duty to pay for rehabilitation referred to above.

(4) The following shall apply for injuries occurring on or after the effective date of this amendatory Act of the 97th General Assembly and only when an employer has an approved preferred provider program pursuant to Section 8.1a on the date the employee sustained his or her accidental injuries:

(A) The employer shall, in writing, on a form promulgated by the Commission, inform the employee of the preferred provider program;

(B) Subsequent to the report of an injury by an employee, the employee may choose in writing at any time to decline the preferred provider program, in which case that would constitute one of the two choices of medical providers to which the employee is entitled under subsection (a)(2) or (a)(3); and

(C) Prior to the report of an injury by an employee, when an employee chooses non-emergency treatment from a provider not within the preferred provider program, that would constitute the employee's one choice of medical providers to which the employee is entitled under subsection (a)(2) or (a)(3).

When an employer and employee so agree in writing, nothing

in this Act prevents an employee whose injury or disability has been established under this Act, from relying in good faith, on treatment by prayer or spiritual means alone, in accordance with the tenets and practice of a recognized church or religious denomination, by a duly accredited practitioner thereof, and having nursing services appropriate therewith, without suffering loss or diminution of the compensation benefits under this Act. However, the employee shall submit to all physical examinations required by this Act. The cost of such treatment and nursing care shall be paid by the employee unless the employer agrees to make such payment.

Where the accidental injury results in the amputation of an arm, hand, leg or foot, or the enucleation of an eye, or the loss of any of the natural teeth, the employer shall furnish an artificial of any such members lost or damaged in accidental injury arising out of and in the course of employment, and shall also furnish the necessary braces in all proper and necessary cases. In cases of the loss of a member or members by amputation, the employer shall, whenever necessary, maintain in good repair, refit or replace the artificial limbs during the lifetime of the employee. Where the accidental injury accompanied by physical injury results in damage to a denture, eye glasses or contact eye lenses, or where the accidental injury results in damage to an artificial member, the employer shall replace or repair such denture, glasses, lenses, or artificial member.

The furnishing by the employer of any such services or appliances is not an admission of liability on the part of the employer to pay compensation.

The furnishing of any such services or appliances or the servicing thereof by the employer is not the payment of compensation.

(b) If the period of temporary total incapacity for work lasts more than 3 working days, weekly compensation as hereinafter provided shall be paid beginning on the 4th day of such temporary total incapacity and continuing as long as the total temporary incapacity lasts. In cases where the temporary total incapacity for work continues for a period of 14 days or more from the day of the accident compensation shall commence on the day after the accident.

1. The compensation rate for temporary total incapacity under this paragraph (b) of this Section shall be equal to 66 2/3% of the employee's average weekly wage computed in accordance with Section 10, provided that it shall be not less than 66 2/3% of the sum of the Federal minimum wage under the Fair Labor Standards Act, or the Illinois minimum wage under the Minimum Wage Law, whichever is more, multiplied by 40 hours. This percentage rate shall be increased by 10% for each spouse and child, not to exceed 100% of the total minimum wage calculation,

nor exceed the employee's average weekly wage computed in accordance with the provisions of Section 10, whichever is

less.

2. The compensation rate in all cases other than for temporary total disability under this paragraph (b), and other than for serious and permanent disfigurement under paragraph (c) and other than for permanent partial disability under subparagraph (2) of paragraph (d) or under paragraph (e), of this Section shall be equal to 66 2/3% of the employee's average weekly wage computed in accordance with the provisions of Section 10, provided that it shall be not less than 66 2/3% of the sum of the Federal minimum wage under the Fair Labor Standards Act, or the Illinois minimum wage under the Minimum Wage Law, whichever is more, multiplied by 40 hours. This percentage rate shall be increased by 10% for each spouse and child, not to exceed 100% of the total minimum wage calculation,
nor exceed the employee's average weekly wage computed in accordance with the provisions of Section 10, whichever is less.

2.1. The compensation rate in all cases of serious and permanent disfigurement under paragraph (c) and of permanent partial disability under subparagraph (2) of paragraph (d) or under paragraph (e) of this Section shall be equal to 60% of the employee's average weekly wage computed in accordance with the provisions of Section 10, provided that it shall be not less than 66 2/3% of the sum of the Federal minimum wage under the Fair Labor Standards

Act, or the Illinois minimum wage under the Minimum Wage Law, whichever is more, multiplied by 40 hours. This percentage rate shall be increased by 10% for each spouse and child, not to exceed 100% of the total minimum wage calculation,

nor exceed the employee's average weekly wage computed in accordance with the provisions of Section 10, whichever is less.

3. As used in this Section the term "child" means a child of the employee including any child legally adopted before the accident or whom at the time of the accident the employee was under legal obligation to support or to whom the employee stood in loco parentis, and who at the time of the accident was under 18 years of age and not emancipated. The term "children" means the plural of "child".

4. All weekly compensation rates provided under subparagraphs 1, 2 and 2.1 of this paragraph (b) of this Section shall be subject to the following limitations:

The maximum weekly compensation rate from July 1, 1975, except as hereinafter provided, shall be 100% of the State's average weekly wage in covered industries under the Unemployment Insurance Act, that being the wage that most closely approximates the State's average weekly wage.

The maximum weekly compensation rate, for the period July 1, 1984, through June 30, 1987, except as hereinafter provided, shall be $293.61. Effective July 1, 1987 and on

July 1 of each year thereafter the maximum weekly compensation rate, except as hereinafter provided, shall be determined as follows: if during the preceding 12 month period there shall have been an increase in the State's average weekly wage in covered industries under the Unemployment Insurance Act, the weekly compensation rate shall be proportionately increased by the same percentage as the percentage of increase in the State's average weekly wage in covered industries under the Unemployment Insurance Act during such period.

The maximum weekly compensation rate, for the period January 1, 1981 through December 31, 1983, except as hereinafter provided, shall be 100% of the State's average weekly wage in covered industries under the Unemployment Insurance Act in effect on January 1, 1981. Effective January 1, 1984 and on January 1, of each year thereafter the maximum weekly compensation rate, except as hereinafter provided, shall be determined as follows: if during the preceding 12 month period there shall have been an increase in the State's average weekly wage in covered industries under the Unemployment Insurance Act, the weekly compensation rate shall be proportionately increased by the same percentage as the percentage of increase in the State's average weekly wage in covered industries under the Unemployment Insurance Act during such period.

From July 1, 1977 and thereafter such maximum weekly compensation rate in death cases under Section 7, and permanent total disability cases under paragraph (f) or subparagraph 18 of paragraph (3) of this Section and for temporary total disability under paragraph (b) of this Section and for amputation of a member or enucleation of an eye under paragraph (e) of this Section shall be increased to 133-1/3% of the State's average weekly wage in covered industries under the Unemployment Insurance Act.

For injuries occurring on or after February 1, 2006, the maximum weekly benefit under paragraph (d)1 of this Section shall be 100% of the State's average weekly wage in covered industries under the Unemployment Insurance Act.

4.1. Any provision herein to the contrary notwithstanding, the weekly compensation rate for compensation payments under subparagraph 18 of paragraph (e) of this Section and under paragraph (f) of this Section and under paragraph (a) of Section 7 and for amputation of a member or enucleation of an eye under paragraph (e) of this Section, shall in no event be less than 50% of the State's average weekly wage in covered industries under the Unemployment Insurance Act.

4.2. Any provision to the contrary notwithstanding, the total compensation payable under Section 7 shall not exceed the greater of $500,000 or 25 years.

5. For the purpose of this Section this State's average

weekly wage in covered industries under the Unemployment Insurance Act on July 1, 1975 is hereby fixed at $228.16 per week and the computation of compensation rates shall be based on the aforesaid average weekly wage until modified as hereinafter provided.

6. The Department of Employment Security of the State shall on or before the first day of December, 1977, and on or before the first day of June, 1978, and on the first day of each December and June of each year thereafter, publish the State's average weekly wage in covered industries under the Unemployment Insurance Act and the Illinois Workers' Compensation Commission shall on the 15th day of January, 1978 and on the 15th day of July, 1978 and on the 15th day of each January and July of each year thereafter, post and publish the State's average weekly wage in covered industries under the Unemployment Insurance Act as last determined and published by the Department of Employment Security. The amount when so posted and published shall be conclusive and shall be applicable as the basis of computation of compensation rates until the next posting and publication as aforesaid.

7. The payment of compensation by an employer or his insurance carrier to an injured employee shall not constitute an admission of the employer's liability to pay compensation.

(c) For any serious and permanent disfigurement to the

hand, head, face, neck, arm, leg below the knee or the chest above the axillary line, the employee is entitled to compensation for such disfigurement, the amount determined by agreement at any time or by arbitration under this Act, at a hearing not less than 6 months after the date of the accidental injury, which amount shall not exceed 150 weeks (if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006) or 162 weeks (if the accidental injury occurs on or after February 1, 2006) at the applicable rate provided in subparagraph 2.1 of paragraph (b) of this Section.

No compensation is payable under this paragraph where compensation is payable under paragraphs (d), (e) or (f) of this Section.

A duly appointed member of a fire department in a city, the population of which exceeds 200,000 according to the last federal or State census, is eligible for compensation under this paragraph only where such serious and permanent disfigurement results from burns.

(d) 1. If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall, except in cases compensated under the specific schedule set forth in paragraph (e) of this Section, receive compensation for the duration of his disability, subject to the limitations as to maximum amounts fixed in

paragraph (b) of this Section, equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident. For accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later.

2. If, as a result of the accident, the employee sustains serious and permanent injuries not covered by paragraphs (c) and (e) of this Section or having sustained injuries covered by the aforesaid paragraphs (c) and (e), he shall have sustained in addition thereto other injuries which injuries do not incapacitate him from pursuing the duties of his employment but which would disable him from pursuing other suitable occupations, or which have otherwise resulted in physical impairment; or if such injuries partially incapacitate him from pursuing the duties of his usual and customary line of employment but do not result in an impairment of earning capacity, or having resulted in an impairment of earning capacity, the employee elects to waive his right to recover under the foregoing subparagraph 1 of paragraph (d) of this Section then in any of the foregoing events, he shall receive

in addition to compensation for temporary total disability under paragraph (b) of this Section, compensation at the rate provided in subparagraph 2.1 of paragraph (b) of this Section for that percentage of 500 weeks that the partial disability resulting from the injuries covered by this paragraph bears to total disability. If the employee shall have sustained a fracture of one or more vertebra or fracture of the skull, the amount of compensation allowed under this Section shall be not less than 6 weeks for a fractured skull and 6 weeks for each fractured vertebra, and in the event the employee shall have sustained a fracture of any of the following facial bones: nasal, lachrymal, vomer, zygoma, maxilla, palatine or mandible, the amount of compensation allowed under this Section shall be not less than 2 weeks for each such fractured bone, and for a fracture of each transverse process not less than 3 weeks. In the event such injuries shall result in the loss of a kidney, spleen or lung, the amount of compensation allowed under this Section shall be not less than 10 weeks for each such organ. Compensation awarded under this subparagraph 2 shall not take into consideration injuries covered under paragraphs (c) and (e) of this Section and the compensation provided in this paragraph shall not affect the employee's right to compensation payable under paragraphs (b), (c) and (e) of this Section for the disabilities therein covered.

(e) For accidental injuries in the following schedule, the employee shall receive compensation for the period of temporary

total incapacity for work resulting from such accidental injury, under subparagraph 1 of paragraph (b) of this Section, and shall receive in addition thereto compensation for a further period for the specific loss herein mentioned, but shall not receive any compensation under any other provisions of this Act. The following listed amounts apply to either the loss of or the permanent and complete loss of use of the member specified, such compensation for the length of time as follows:

1. Thumb-

70 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

76 weeks if the accidental injury occurs on or after February 1, 2006.

2. First, or index finger-

40 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

43 weeks if the accidental injury occurs on or after February 1, 2006.

3. Second, or middle finger-

35 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

38 weeks if the accidental injury occurs on or after February 1, 2006.

4. Third, or ring finger-

25 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

27 weeks if the accidental injury occurs on or after February 1, 2006.

5. Fourth, or little finger-

20 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

22 weeks if the accidental injury occurs on or after February 1, 2006.

6. Great toe-

35 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

38 weeks if the accidental injury occurs on or after February 1, 2006.

7. Each toe other than great toe-

12 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

13 weeks if the accidental injury occurs on or after February 1, 2006.

8. The loss of the first or distal phalanx of the thumb or of any finger or toe shall be considered to be equal to

the loss of one-half of such thumb, finger or toe and the compensation payable shall be one-half of the amount above specified. The loss of more than one phalanx shall be considered as the loss of the entire thumb, finger or toe. In no case shall the amount received for more than one finger exceed the amount provided in this schedule for the loss of a hand.

9. Hand-

190 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

205 weeks if the accidental injury occurs on or after February 1, 2006.

<u>190 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 97th General Assembly and if the accidental injury involves carpal tunnel syndrome due to repetitive or cumulative trauma, in which case the permanent partial disability shall not exceed 15% loss of use of the hand, except for cause shown by clear and convincing evidence and in which case the award shall not exceed 30% loss of use of the hand.</u>

The loss of 2 or more digits, or one or more phalanges of 2 or more digits, of a hand may be compensated on the basis of partial loss of use of a hand, provided, further, that the loss of 4 digits, or the loss of use of 4 digits,

in the same hand shall constitute the complete loss of a hand.

10. Arm-

235 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

253 weeks if the accidental injury occurs on or after February 1, 2006.

Where an accidental injury results in the amputation of an arm below the elbow, such injury shall be compensated as a loss of an arm. Where an accidental injury results in the amputation of an arm above the elbow, compensation for an additional 15 weeks (if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006) or an additional 17 weeks (if the accidental injury occurs on or after February 1, 2006) shall be paid, except where the accidental injury results in the amputation of an arm at the shoulder joint, or so close to shoulder joint that an artificial arm cannot be used, or results in the disarticulation of an arm at the shoulder joint, in which case compensation for an additional 65 weeks (if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006) or an additional 70 weeks (if the accidental injury occurs on or after February 1, 2006)

shall be paid.

11. Foot-

155 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

167 weeks if the accidental injury occurs on or after February 1, 2006.

12. Leg-

200 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

215 weeks if the accidental injury occurs on or after February 1, 2006.

Where an accidental injury results in the amputation of a leg below the knee, such injury shall be compensated as loss of a leg. Where an accidental injury results in the amputation of a leg above the knee, compensation for an additional 25 weeks (if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006) or an additional 27 weeks (if the accidental injury occurs on or after February 1, 2006) shall be paid, except where the accidental injury results in the amputation of a leg at the hip joint, or so close to the hip joint that an artificial leg cannot be used, or results in the disarticulation of a leg at the hip joint, in which case compensation for an

additional 75 weeks (if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006) or an additional 81 weeks (if the accidental injury occurs on or after February 1, 2006) shall be paid.

13. Eye-

150 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

162 weeks if the accidental injury occurs on or after February 1, 2006.

Where an accidental injury results in the enucleation of an eye, compensation for an additional 10 weeks (if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006) or an additional 11 weeks (if the accidental injury occurs on or after February 1, 2006) shall be paid.

14. Loss of hearing of one ear-

50 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

54 weeks if the accidental injury occurs on or after February 1, 2006.

Total and permanent loss of hearing of both ears-

200 weeks if the accidental injury occurs on or

after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

215 weeks if the accidental injury occurs on or after February 1, 2006.

15. Testicle-

50 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

54 weeks if the accidental injury occurs on or after February 1, 2006.

Both testicles-

150 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

162 weeks if the accidental injury occurs on or after February 1, 2006.

16. For the permanent partial loss of use of a member or sight of an eye, or hearing of an ear, compensation during that proportion of the number of weeks in the foregoing schedule provided for the loss of such member or sight of an eye, or hearing of an ear, which the partial loss of use thereof bears to the total loss of use of such member, or sight of eye, or hearing of an ear.

(a) Loss of hearing for compensation purposes shall be confined to the frequencies of 1,000, 2,000 and 3,000 cycles per second. Loss of hearing ability

for frequency tones above 3,000 cycles per second are not to be considered as constituting disability for hearing.

(b) The percent of hearing loss, for purposes of the determination of compensation claims for occupational deafness, shall be calculated as the average in decibels for the thresholds of hearing for the frequencies of 1,000, 2,000 and 3,000 cycles per second. Pure tone air conduction audiometric instruments, approved by nationally recognized authorities in this field, shall be used for measuring hearing loss. If the losses of hearing average 30 decibels or less in the 3 frequencies, such losses of hearing shall not then constitute any compensable hearing disability. If the losses of hearing average 85 decibels or more in the 3 frequencies, then the same shall constitute and be total or 100% compensable hearing loss.

(c) In measuring hearing impairment, the lowest measured losses in each of the 3 frequencies shall be added together and divided by 3 to determine the average decibel loss. For every decibel of loss exceeding 30 decibels an allowance of 1.82% shall be made up to the maximum of 100% which is reached at 85 decibels.

(d) If a hearing loss is established to have

existed on July 1, 1975 by audiometric testing the employer shall not be liable for the previous loss so established nor shall he be liable for any loss for which compensation has been paid or awarded.

(e) No consideration shall be given to the question of whether or not the ability of an employee to understand speech is improved by the use of a hearing aid.

(f) No claim for loss of hearing due to industrial noise shall be brought against an employer or allowed unless the employee has been exposed for a period of time sufficient to cause permanent impairment to noise levels in excess of the following:

Sound Level DBA

Slow Response	Hours Per Day
90	8
92	6
95	4
97	3
100	2
102	1-1/2
105	1
110	1/2
115	1/4

This subparagraph (f) shall not be applied in cases of hearing loss resulting from trauma or explosion.

17. In computing the compensation to be paid to any employee who, before the accident for which he claims compensation, had before that time sustained an injury resulting in the loss by amputation or partial loss by amputation of any member, including hand, arm, thumb or fingers, leg, foot or any toes, such loss or partial loss of any such member shall be deducted from any award made for the subsequent injury. For the permanent loss of use or the permanent partial loss of use of any such member or the partial loss of sight of an eye, for which compensation has been paid, then such loss shall be taken into consideration and deducted from any award for the subsequent injury.

18. The specific case of loss of both hands, both arms, or both feet, or both legs, or both eyes, or of any two thereof, or the permanent and complete loss of the use thereof, constitutes total and permanent disability, to be compensated according to the compensation fixed by paragraph (f) of this Section. These specific cases of total and permanent disability do not exclude other cases.

Any employee who has previously suffered the loss or permanent and complete loss of the use of any of such members, and in a subsequent independent accident loses another or suffers the permanent and complete loss of the use of any one of such members the employer for whom the injured employee is working at the time of the last independent accident is liable to pay compensation only for

the loss or permanent and complete loss of the use of the member occasioned by the last independent accident.

19. In a case of specific loss and the subsequent death of such injured employee from other causes than such injury leaving a widow, widower, or dependents surviving before payment or payment in full for such injury, then the amount due for such injury is payable to the widow or widower and, if there be no widow or widower, then to such dependents, in the proportion which such dependency bears to total dependency.

Beginning July 1, 1980, and every 6 months thereafter, the Commission shall examine the Second Injury Fund and when, after deducting all advances or loans made to such Fund, the amount therein is $500,000 then the amount required to be paid by employers pursuant to paragraph (f) of Section 7 shall be reduced by one-half. When the Second Injury Fund reaches the sum of $600,000 then the payments shall cease entirely. However, when the Second Injury Fund has been reduced to $400,000, payment of one-half of the amounts required by paragraph (f) of Section 7 shall be resumed, in the manner herein provided, and when the Second Injury Fund has been reduced to $300,000, payment of the full amounts required by paragraph (f) of Section 7 shall be resumed, in the manner herein provided. The Commission shall make the changes in payment effective by general order, and the changes in payment become immediately effective for all cases coming before the

Commission thereafter either by settlement agreement or final order, irrespective of the date of the accidental injury.

On August 1, 1996 and on February 1 and August 1 of each subsequent year, the Commission shall examine the special fund designated as the "Rate Adjustment Fund" and when, after deducting all advances or loans made to said fund, the amount therein is $4,000,000, the amount required to be paid by employers pursuant to paragraph (f) of Section 7 shall be reduced by one-half. When the Rate Adjustment Fund reaches the sum of $5,000,000 the payment therein shall cease entirely. However, when said Rate Adjustment Fund has been reduced to $3,000,000 the amounts required by paragraph (f) of Section 7 shall be resumed in the manner herein provided.

(f) In case of complete disability, which renders the employee wholly and permanently incapable of work, or in the specific case of total and permanent disability as provided in subparagraph 18 of paragraph (e) of this Section, compensation shall be payable at the rate provided in subparagraph 2 of paragraph (b) of this Section for life.

An employee entitled to benefits under paragraph (f) of this Section shall also be entitled to receive from the Rate Adjustment Fund provided in paragraph (f) of Section 7 of the supplementary benefits provided in paragraph (g) of this Section 8.

If any employee who receives an award under this paragraph afterwards returns to work or is able to do so, and earns or is

able to earn as much as before the accident, payments under such award shall cease. If such employee returns to work, or is able to do so, and earns or is able to earn part but not as much as before the accident, such award shall be modified so as to conform to an award under paragraph (d) of this Section. If such award is terminated or reduced under the provisions of this paragraph, such employees have the right at any time within 30 months after the date of such termination or reduction to file petition with the Commission for the purpose of determining whether any disability exists as a result of the original accidental injury and the extent thereof.

Disability as enumerated in subdivision 18, paragraph (e) of this Section is considered complete disability.

If an employee who had previously incurred loss or the permanent and complete loss of use of one member, through the loss or the permanent and complete loss of the use of one hand, one arm, one foot, one leg, or one eye, incurs permanent and complete disability through the loss or the permanent and complete loss of the use of another member, he shall receive, in addition to the compensation payable by the employer and after such payments have ceased, an amount from the Second Injury Fund provided for in paragraph (f) of Section 7, which, together with the compensation payable from the employer in whose employ he was when the last accidental injury was incurred, will equal the amount payable for permanent and complete disability as provided in this paragraph of this

Section.

The custodian of the Second Injury Fund provided for in paragraph (f) of Section 7 shall be joined with the employer as a party respondent in the application for adjustment of claim. The application for adjustment of claim shall state briefly and in general terms the approximate time and place and manner of the loss of the first member.

In its award the Commission or the Arbitrator shall specifically find the amount the injured employee shall be weekly paid, the number of weeks compensation which shall be paid by the employer, the date upon which payments begin out of the Second Injury Fund provided for in paragraph (f) of Section 7 of this Act, the length of time the weekly payments continue, the date upon which the pension payments commence and the monthly amount of the payments. The Commission shall 30 days after the date upon which payments out of the Second Injury Fund have begun as provided in the award, and every month thereafter, prepare and submit to the State Comptroller a voucher for payment for all compensation accrued to that date at the rate fixed by the Commission. The State Comptroller shall draw a warrant to the injured employee along with a receipt to be executed by the injured employee and returned to the Commission. The endorsed warrant and receipt is a full and complete acquittance to the Commission for the payment out of the Second Injury Fund. No other appropriation or warrant is necessary for payment out of the Second Injury Fund. The Second

Injury Fund is appropriated for the purpose of making payments according to the terms of the awards.

As of July 1, 1980 to July 1, 1982, all claims against and obligations of the Second Injury Fund shall become claims against and obligations of the Rate Adjustment Fund to the extent there is insufficient money in the Second Injury Fund to pay such claims and obligations. In that case, all references to "Second Injury Fund" in this Section shall also include the Rate Adjustment Fund.

(g) Every award for permanent total disability entered by the Commission on and after July 1, 1965 under which compensation payments shall become due and payable after the effective date of this amendatory Act, and every award for death benefits or permanent total disability entered by the Commission on and after the effective date of this amendatory Act shall be subject to annual adjustments as to the amount of the compensation rate therein provided. Such adjustments shall first be made on July 15, 1977, and all awards made and entered prior to July 1, 1975 and on July 15 of each year thereafter. In all other cases such adjustment shall be made on July 15 of the second year next following the date of the entry of the award and shall further be made on July 15 annually thereafter. If during the intervening period from the date of the entry of the award, or the last periodic adjustment, there shall have been an increase in the State's average weekly wage in covered industries under the Unemployment Insurance Act, the weekly

compensation rate shall be proportionately increased by the same percentage as the percentage of increase in the State's average weekly wage in covered industries under the Unemployment Insurance Act. The increase in the compensation rate under this paragraph shall in no event bring the total compensation rate to an amount greater than the prevailing maximum rate at the time that the annual adjustment is made. Such increase shall be paid in the same manner as herein provided for payments under the Second Injury Fund to the injured employee, or his dependents, as the case may be, out of the Rate Adjustment Fund provided in paragraph (f) of Section 7 of this Act. Payments shall be made at the same intervals as provided in the award or, at the option of the Commission, may be made in quarterly payment on the 15th day of January, April, July and October of each year. In the event of a decrease in such average weekly wage there shall be no change in the then existing compensation rate. The within paragraph shall not apply to cases where there is disputed liability and in which a compromise lump sum settlement between the employer and the injured employee, or his dependents, as the case may be, has been duly approved by the Illinois Workers' Compensation Commission.

Provided, that in cases of awards entered by the Commission for injuries occurring before July 1, 1975, the increases in the compensation rate adjusted under the foregoing provision of this paragraph (g) shall be limited to increases in the State's

average weekly wage in covered industries under the Unemployment Insurance Act occurring after July 1, 1975.

For every accident occurring on or after July 20, 2005 but before the effective date of this amendatory Act of the 94th General Assembly (Senate Bill 1283 of the 94th General Assembly), the annual adjustments to the compensation rate in awards for death benefits or permanent total disability, as provided in this Act, shall be paid by the employer. The adjustment shall be made by the employer on July 15 of the second year next following the date of the entry of the award and shall further be made on July 15 annually thereafter. If during the intervening period from the date of the entry of the award, or the last periodic adjustment, there shall have been an increase in the State's average weekly wage in covered industries under the Unemployment Insurance Act, the employer shall increase the weekly compensation rate proportionately by the same percentage as the percentage of increase in the State's average weekly wage in covered industries under the Unemployment Insurance Act. The increase in the compensation rate under this paragraph shall in no event bring the total compensation rate to an amount greater than the prevailing maximum rate at the time that the annual adjustment is made. In the event of a decrease in such average weekly wage there shall be no change in the then existing compensation rate. Such increase shall be paid by the employer in the same manner and at the same intervals as the payment of compensation in the

award. This paragraph shall not apply to cases where there is disputed liability and in which a compromise lump sum settlement between the employer and the injured employee, or his or her dependents, as the case may be, has been duly approved by the Illinois Workers' Compensation Commission.

The annual adjustments for every award of death benefits or permanent total disability involving accidents occurring before July 20, 2005 and accidents occurring on or after the effective date of this amendatory Act of the 94th General Assembly (Senate Bill 1283 of the 94th General Assembly) shall continue to be paid from the Rate Adjustment Fund pursuant to this paragraph and Section 7(f) of this Act.

(h) In case death occurs from any cause before the total compensation to which the employee would have been entitled has been paid, then in case the employee leaves any widow, widower, child, parent (or any grandchild, grandparent or other lineal heir or any collateral heir dependent at the time of the accident upon the earnings of the employee to the extent of 50% or more of total dependency) such compensation shall be paid to the beneficiaries of the deceased employee and distributed as provided in paragraph (g) of Section 7.

(h-1) In case an injured employee is under legal disability at the time when any right or privilege accrues to him or her under this Act, a guardian may be appointed pursuant to law, and may, on behalf of such person under legal disability, claim and exercise any such right or privilege with the same effect

as if the employee himself or herself had claimed or exercised the right or privilege. No limitations of time provided by this Act run so long as the employee who is under legal disability is without a conservator or guardian.

(i) In case the injured employee is under 16 years of age at the time of the accident and is illegally employed, the amount of compensation payable under paragraphs (b), (c), (d), (e) and (f) of this Section is increased 50%.

However, where an employer has on file an employment certificate issued pursuant to the Child Labor Law or work permit issued pursuant to the Federal Fair Labor Standards Act, as amended, or a birth certificate properly and duly issued, such certificate, permit or birth certificate is conclusive evidence as to the age of the injured minor employee for the purposes of this Section.

Nothing herein contained repeals or amends the provisions of the Child Labor Law relating to the employment of minors under the age of 16 years.

(j) 1. In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be credited to or

against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act. In such event, the period of time for giving notice of accidental injury and filing application for adjustment of claim does not commence to run until the termination of such payments. This paragraph does not apply to payments made under any group plan which would have been payable irrespective of an accidental injury under this Act. Any employer receiving such credit shall keep such employee safe and harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to the extent of such credit.

Any excess benefits paid to or on behalf of a State employee by the State Employees' Retirement System under Article 14 of the Illinois Pension Code on a death claim or disputed disability claim shall be credited against any payments made or to be made by the State of Illinois to or on behalf of such employee under this Act, except for payments for medical expenses which have already been incurred at the time of the award. The State of Illinois shall directly reimburse the State Employees' Retirement System to the extent of such credit.

2. Nothing contained in this Act shall be construed to give the employer or the insurance carrier the right to credit for any benefits or payments received by the employee other than compensation payments provided by this Act, and where the

employee receives payments other than compensation payments, whether as full or partial salary, group insurance benefits, bonuses, annuities or any other payments, the employer or insurance carrier shall receive credit for each such payment only to the extent of the compensation that would have been payable during the period covered by such payment.

3. The extension of time for the filing of an Application for Adjustment of Claim as provided in paragraph 1 above shall not apply to those cases where the time for such filing had expired prior to the date on which payments or benefits enumerated herein have been initiated or resumed. Provided however that this paragraph 3 shall apply only to cases wherein the payments or benefits hereinabove enumerated shall be received after July 1, 1969.

(Source: P.A. 93-721, eff. 1-1-05; 94-277, eff. 7-20-05; 94-695, eff. 11-16-05.)

(820 ILCS 305/8.1a new)

Sec. 8.1a. Preferred provider programs. Starting on the effective date of this amendatory Act of the 97th General Assembly, to satisfy its liabilities under this Act for the provision of medical treatment to injured employees, an employer may utilize a preferred provider program approved by the Illinois Department of Insurance as in compliance with Sections 370k, 370l, 370m, and 370p of Article XX-1/2 of the Illinois Insurance Code. For the purposes of compliance with

these Sections, the employee shall be considered the "beneficiary" and the employer shall be considered the "insured". Employers and insurers contracting directly with providers or utilizing multiple preferred provider programs to implement a preferred provider program providing workers' compensation benefits shall be subject to the above requirements of Article XX-1/2 applicable to administrators with regard to such program, with the exception of Section 370l of the Illinois Insurance Code.

(a) In addition to the above requirements of Article XX-1/2 of the Illinois Insurance Code, all preferred provider programs under this Section shall meet the following requirements:

(1) The provider network shall include an adequate number of occupational and non-occupational providers.

(2) The provider network shall include an adequate number and type of physicians or other providers to treat common injuries experienced by injured workers in the geographic area where the employees reside.

(3) Medical treatment for injuries shall be readily available at reasonable times to all employees. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees.

(4) Physician compensation shall not be structured in order to achieve the goal of inappropriately reducing, delaying, or denying medical treatment or restricting access to medical treatment.

(5) Before entering into any agreement under this Section, a program shall establish terms and conditions that must be met by noninstitutional providers wishing to enter into an agreement with the program. These terms and conditions may not discriminate unreasonably against or among noninstitutional providers. Neither difference in prices among noninstitutional providers produced by a process of individual negotiation nor price differences among other noninstitutional providers in different geographical areas or different specialties constitutes unreasonable discrimination.

(b) The administrator of any preferred provider program under this Act that uses economic evaluation shall file with the Director of Insurance a description of any policies and procedures related to economic evaluation utilized by the program. The filing shall describe how these policies and procedures are used in utilization review, peer review, incentive and penalty programs, and in provider retention and termination decisions. The Director of Insurance may deny approval of any preferred provider program that uses any policy or procedure of economic evaluation to inappropriately reduce, delay or deny medical treatment, or to restrict access to medical treatment. Evaluation of providers based upon objective medical quality and patient outcome measurements, appropriate use of best clinical practices and evidence based medicine, and use of health information technology shall be

permitted. If approved, the employer shall provide a copy of the filing to all participating providers.

(1) The Director of the Department of Insurance shall make each administrator's filing available to the public upon request. The Director of the Department of Insurance may not publicly disclose any information submitted pursuant to this Section that is determined by the Director of the Department of Insurance to be confidential, proprietary, or trade secret information pursuant to State or federal law.

(2) For the purposes of this subsection (b), "economic evaluation" shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association. Economic evaluation shall not include negotiated rates with a provider.

(c) Except for the provisions of subsection (a)(4) of Section 8 and for injuries occurring on or after the effective date of this amendatory Act of the 97th General Assembly, an employee of an employer utilizing a preferred provider program shall only be allowed to select a participating network provider from the network. An employer shall be responsible for: (i) all first aid and emergency treatment; (ii) all

medical, surgical, and hospital services provided by the participating network provider initially selected by the employee or by any other participating network provider recommended by the initial participating network provider or any subsequent participating network provider in the chain of referrals from the initial participating network provider; and (iii) all medical, surgical, and hospital services provided by the participating network provider subsequently chosen by the employee or by any other participating network provider recommended by the subsequent participating network provider or any subsequent participating network provider in the chain of referrals from the second participating network provider. An employer shall not be liable for services determined by the Commission not to be compensable. An employer shall not be liable for medical services provided by a non-authorized provider when proper notice is provided to the injured worker.

(1) When the injured employee notifies the employer of the injury or files a claim for workers' compensation with the employer, the employer shall notify the employee of his or her right to be treated by a physician of his or her choice from the preferred provider network established pursuant to this Section, and the method by which the list of participating network providers may be accessed by the employee, except as provided in subsection (a)(4) of Section 8.

(2) Consistent with Article XX-1/2 of the Illinois

Insurance Code, treatment by a specialist who is not a member of the preferred provider network shall be permitted on a case-by-case basis if the medical provider network does not contain a physician who can provide the approved treatment, and if the employee has complied with any pre-authorization requirements of the preferred provider network. Consent for the employee to visit an out-of-network provider may not be unreasonably withheld. When a non-network provider is authorized pursuant to this subparagraph (2), the non-network provider shall not hold an employee liable for costs except as provided in subsection (e) of Section 8.2.

(3) The Director shall not approve, and may withdraw prior approval of, a preferred provider program that fails to provide an injured employee with sufficient access to necessary treating physicians, surgeons, and specialists.

(d) Except as provided in subsection (a)(4) of Section 8, upon a finding by the Commission that the care being rendered by the employee's second choice of provider within the employer's network is improper or inadequate, the employee may then choose a provider outside of the network at the employer's expense. The Commission shall issue a decision on any petition filed pursuant to this Section within 5 working days.

(e) The Director of the Department of Insurance may promulgate such rules as are necessary to carry out the provisions of this Section relating to approval and regulation

of preferred provider programs.

(820 ILCS 305/8.1b new)

Sec. 8.1b. Determination of permanent partial disability. For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical

records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

(820 ILCS 305/8.2)

Sec. 8.2. Fee schedule.

(a) Except as provided for in subsection (c), for procedures, treatments, or services covered under this Act and rendered or to be rendered on and after February 1, 2006, the maximum allowable payment shall be 90% of the 80th percentile of charges and fees as determined by the Commission utilizing information provided by employers' and insurers' national databases, with a minimum of 12,000,000 Illinois line item charges and fees comprised of health care provider and hospital charges and fees as of August 1, 2004 but not earlier than August 1, 2002. These charges and fees are provider billed amounts and shall not include discounted charges. The 80th percentile is the point on an ordered data set from low to high such that 80% of the cases are below or equal to that point and at most 20% are above or equal to that point. The Commission shall adjust these historical charges and fees as of August 1, 2004 by the Consumer Price Index-U for the period August 1, 2004 through September 30, 2005. The Commission shall establish fee schedules for procedures, treatments, or services for

hospital inpatient, hospital outpatient, emergency room and trauma, ambulatory surgical treatment centers, and professional services. These charges and fees shall be designated by geozip or any smaller geographic unit. The data shall in no way identify or tend to identify any patient, employer, or health care provider. As used in this Section, "geozip" means a three-digit zip code based on data similarities, geographical similarities, and frequencies. A geozip does not cross state boundaries. As used in this Section, "three-digit zip code" means a geographic area in which all zip codes have the same first 3 digits. If a geozip does not have the necessary number of charges and fees to calculate a valid percentile for a specific procedure, treatment, or service, the Commission may combine data from the geozip with up to 4 other geozips that are demographically and economically similar and exhibit similarities in data and frequencies until the Commission reaches 9 charges or fees for that specific procedure, treatment, or service. In cases where the compiled data contains less than 9 charges or fees for a procedure, treatment, or service, reimbursement shall occur at 76% of charges and fees as determined by the Commission in a manner consistent with the provisions of this paragraph. Providers of out-of-state procedures, treatments, services, products, or supplies shall be reimbursed at the lesser of that state's fee schedule amount or the fee schedule amount for the region in which the employee resides. If no fee schedule exists

in that state, the provider shall be reimbursed at the lesser of the actual charge or the fee schedule amount for the region in which the employee resides. ~~The Commission has the authority to set the maximum allowable payment to providers of out of state procedures, treatments, or services covered under this Act in a manner consistent with this Section.~~ Not later than September 30 in 2006 and each year thereafter, the Commission shall automatically increase or decrease the maximum allowable payment for a procedure, treatment, or service established and in effect on January 1 of that year by the percentage change in the Consumer Price Index-U for the 12 month period ending August 31 of that year. The increase or decrease shall become effective on January 1 of the following year. As used in this Section, "Consumer Price Index-U" means the index published by the Bureau of Labor Statistics of the U.S. Department of Labor, that measures the average change in prices of all goods and services purchased by all urban consumers, U.S. city average, all items, 1982-84=100.

(a-1) Notwithstanding the provisions of subsection (a) and unless otherwise indicated, the following provisions shall apply to the medical fee schedule starting on September 1, 2011:

(1) The Commission shall establish and maintain fee schedules for procedures, treatments, products, services, or supplies for hospital inpatient, hospital outpatient, emergency room, ambulatory surgical treatment centers,

accredited ambulatory surgical treatment facilities, prescriptions filled and dispensed outside of a licensed pharmacy, dental services, and professional services. This fee schedule shall be based on the fee schedule amounts already established by the Commission pursuant to subsection (a) of this Section. However, starting on January 1, 2012, these fee schedule amounts shall be grouped into geographic regions in the following manner:

(A) Four regions for non-hospital fee schedule amounts shall be utilized:

(i) Cook County;

(ii) DuPage, Kane, Lake, and Will Counties;

(iii) Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph, St. Clair, and Washington Counties; and

(iv) All other counties of the State.

(B) Fourteen regions for hospital fee schedule amounts shall be utilized:

(i) Cook, DuPage, Will, Kane, McHenry, DeKalb, Kendall, and Grundy Counties;

(ii) Kankakee County;

(iii) Madison, St. Clair, Macoupin, Clinton, Monroe, Jersey, Bond, and Calhoun Counties;

(iv) Winnebago and Boone Counties;

(v) Peoria, Tazewell, Woodford, Marshall, and Stark Counties;

(vi) Champaign, Piatt, and Ford Counties;

(vii) Rock Island, Henry, and Mercer Counties;

(viii) Sangamon and Menard Counties;

(ix) McLean County;

(x) Lake County;

(xi) Macon County;

(xii) Vermilion County;

(xiii) Alexander County; and

(xiv) All other counties of the State.

(2) If a geozip, as defined in subsection (a) of this Section, overlaps into one or more of the regions set forth in this Section, then the Commission shall average or repeat the charges and fees in a geozip in order to designate charges and fees for each region.

(3) In cases where the compiled data contains less than 9 charges or fees for a procedure, treatment, product, supply, or service or where the fee schedule amount cannot be determined by the non-discounted charge data, non-Medicare relative values and conversion factors derived from established fee schedule amounts, coding crosswalks, or other data as determined by the Commission, reimbursement shall occur at 76% of charges and fees until September 1, 2011 and 53.2% of charges and fees thereafter as determined by the Commission in a manner consistent with the provisions of this paragraph.

(4) To establish additional fee schedule amounts, the

Commission shall utilize provider non-discounted charge data, non-Medicare relative values and conversion factors derived from established fee schedule amounts, and coding crosswalks. The Commission may establish additional fee schedule amounts based on either the charge or cost of the procedure, treatment, product, supply, or service.

(5) Implants shall be reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges whether or not the implant charge is submitted by a provider in conjunction with a bill for all other services associated with the implant, submitted by a provider on a separate claim form, submitted by a distributor, or submitted by the manufacturer of the implant. "Implants" include the following codes or any substantially similar updated code as determined by the Commission: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). Non-implantable devices or supplies within these codes shall be reimbursed at 65% of actual charge, which is the provider's normal rates under its standard chargemaster. A standard chargemaster is the provider's list of charges for procedures, treatments, products, supplies, or services used to bill payers in a consistent manner.

(6) The Commission shall automatically update all codes and associated rules with the version of the codes and rules valid on January 1 of that year.

(a-2) For procedures, treatments, services, or supplies covered under this Act and rendered or to be rendered on or after September 1, 2011, the maximum allowable payment shall be 70% of the fee schedule amounts, which shall be adjusted yearly by the Consumer Price Index-U, as described in subsection (a) of this Section.

(a-3) Prescriptions filled and dispensed outside of a licensed pharmacy shall be subject to a fee schedule that shall not exceed the Average Wholesale Price (AWP) plus a dispensing fee of $4.18. AWP or its equivalent as registered by the National Drug Code shall be set forth for that drug on that date as published in Medispan.

(b) Notwithstanding the provisions of subsection (a), if the Commission finds that there is a significant limitation on access to quality health care in either a specific field of health care services or a specific geographic limitation on access to health care, it may change the Consumer Price Index-U increase or decrease for that specific field or specific geographic limitation on access to health care to address that limitation.

(c) The Commission shall establish by rule a process to review those medical cases or outliers that involve extra-ordinary treatment to determine whether to make an

additional adjustment to the maximum payment within a fee schedule for a procedure, treatment, or service.

(d) When a patient notifies a provider that the treatment, procedure, or service being sought is for a work-related illness or injury and furnishes the provider the name and address of the responsible employer, the provider shall bill the employer directly. The employer shall make payment and providers shall submit bills and records in accordance with the provisions of this Section.

(1) All payments to providers for treatment provided pursuant to this Act shall be made within 30 ~~60~~ days of receipt of the bills as long as the claim contains substantially all the required data elements necessary to adjudicate the bills.

(2) If the claim does not contain substantially all the required data elements necessary to adjudicate the bill, or the claim is denied for any other reason, in whole or in part, the employer or insurer shall provide written notification, explaining the basis for the denial and describing any additional necessary data elements, to the provider within 30 days of receipt of the bill.

(3) In the case of nonpayment to a provider within 30 ~~60~~ days of receipt of the bill which contained substantially all of the required data elements necessary to adjudicate the bill or nonpayment to a provider of a portion of such a bill up to the lesser of the actual

charge or the payment level set by the Commission in the fee schedule established in this Section, the bill, or portion of the bill, shall incur interest at a rate of 1% per month payable to the provider. Any required interest payments shall be made within 30 days after payment.

(e) Except as provided in subsections (e-5), (e-10), and (e-15), a provider shall not hold an employee liable for costs related to a non-disputed procedure, treatment, or service rendered in connection with a compensable injury. The provisions of subsections (e-5), (e-10), (e-15), and (e-20) shall not apply if an employee provides information to the provider regarding participation in a group health plan. If the employee participates in a group health plan, the provider may submit a claim for services to the group health plan. If the claim for service is covered by the group health plan, the employee's responsibility shall be limited to applicable deductibles, co-payments, or co-insurance. Except as provided under subsections (e-5), (e-10), (e-15), and (e-20), a provider shall not bill or otherwise attempt to recover from the employee the difference between the provider's charge and the amount paid by the employer or the insurer on a compensable injury, or for medical services or treatment determined by the Commission to be excessive or unnecessary.

(e-5) If an employer notifies a provider that the employer does not consider the illness or injury to be compensable under this Act, the provider may seek payment of the provider's

actual charges from the employee for any procedure, treatment, or service rendered. Once an employee informs the provider that there is an application filed with the Commission to resolve a dispute over payment of such charges, the provider shall cease any and all efforts to collect payment for the services that are the subject of the dispute. Any statute of limitations or statute of repose applicable to the provider's efforts to collect payment from the employee shall be tolled from the date that the employee files the application with the Commission until the date that the provider is permitted to resume collection efforts under the provisions of this Section.

(e-10) If an employer notifies a provider that the employer will pay only a portion of a bill for any procedure, treatment, or service rendered in connection with a compensable illness or disease, the provider may seek payment from the employee for the remainder of the amount of the bill up to the lesser of the actual charge, negotiated rate, if applicable, or the payment level set by the Commission in the fee schedule established in this Section. Once an employee informs the provider that there is an application filed with the Commission to resolve a dispute over payment of such charges, the provider shall cease any and all efforts to collect payment for the services that are the subject of the dispute. Any statute of limitations or statute of repose applicable to the provider's efforts to collect payment from the employee shall be tolled from the date that the employee files the application with the Commission

until the date that the provider is permitted to resume collection efforts under the provisions of this Section.

(e-15) When there is a dispute over the compensability of or amount of payment for a procedure, treatment, or service, and a case is pending or proceeding before an Arbitrator or the Commission, the provider may mail the employee reminders that the employee will be responsible for payment of any procedure, treatment or service rendered by the provider. The reminders must state that they are not bills, to the extent practicable include itemized information, and state that the employee need not pay until such time as the provider is permitted to resume collection efforts under this Section. The reminders shall not be provided to any credit rating agency. The reminders may request that the employee furnish the provider with information about the proceeding under this Act, such as the file number, names of parties, and status of the case. If an employee fails to respond to such request for information or fails to furnish the information requested within 90 days of the date of the reminder, the provider is entitled to resume any and all efforts to collect payment from the employee for the services rendered to the employee and the employee shall be responsible for payment of any outstanding bills for a procedure, treatment, or service rendered by a provider.

(e-20) Upon a final award or judgment by an Arbitrator or the Commission, or a settlement agreed to by the employer and the employee, a provider may resume any and all efforts to

collect payment from the employee for the services rendered to the employee and the employee shall be responsible for payment of any outstanding bills for a procedure, treatment, or service rendered by a provider as well as the interest awarded under subsection (d) of this Section. In the case of a procedure, treatment, or service deemed compensable, the provider shall not require a payment rate, excluding the interest provisions under subsection (d), greater than the lesser of the actual charge or the payment level set by the Commission in the fee schedule established in this Section. Payment for services deemed not covered or not compensable under this Act is the responsibility of the employee unless a provider and employee have agreed otherwise in writing. Services not covered or not compensable under this Act are not subject to the fee schedule in this Section.

(f) Nothing in this Act shall prohibit an employer or insurer from contracting with a health care provider or group of health care providers for reimbursement levels for benefits under this Act different from those provided in this Section.

(g) On or before January 1, 2010 the Commission shall provide to the Governor and General Assembly a report regarding the implementation of the medical fee schedule and the index used for annual adjustment to that schedule as described in this Section.

(Source: P.A. 94-277, eff. 7-20-05; 94-695, eff. 11-16-05.)

(820 ILCS 305/8.2a new)

Sec. 8.2a. Electronic claims.

(a) The Director of Insurance shall adopt rules to do all of the following:

(1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.

(2) Require acceptance by employers and insurers of electronic claims for payment of medical services.

(3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.

(b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996 and standards adopted under the Illinois Health Information Exchange and Technology Act.

(c) The rules requiring employers and insurers to accept electronic claims for payment of medical services shall be proposed on or before January 1, 2012, and shall require all employers and insurers to accept electronic claims for payment of medical services on or before June 30, 2012.

(d) The Director of Insurance shall by rule establish criteria for granting exceptions to employers, insurance carriers, and health care providers who are unable to submit or accept medical bills electronically.

(820 ILCS 305/8.7)

Sec. 8.7. Utilization review programs.

(a) As used in this Section:

"Utilization review" means the evaluation of proposed or provided health care services to determine the appropriateness of both the level of health care services medically necessary and the quality of health care services provided to a patient, including evaluation of their efficiency, efficacy, and appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. The evaluation must be accomplished by means of a system that identifies the utilization of health care services based on standards of care of ~~or~~ nationally recognized peer review guidelines as well as nationally recognized treatment guidelines and evidence-based medicine ~~evidence~~ based upon standards as provided in this Act. Utilization techniques may include prospective review, second opinions, concurrent review, discharge planning, peer review, independent medical examinations, and retrospective review (for purposes of this sentence, retrospective review shall be applicable to services rendered on or after July 20, 2005). Nothing in this Section applies to prospective review of necessary first aid or emergency treatment.

(b) No person may conduct a utilization review program for workers' compensation services in this State unless once every 2 years the person registers the utilization review program

with the Department of Insurance ~~Financial and Professional Regulation~~ and certifies compliance with the Workers' Compensation Utilization Management standards or Health Utilization Management Standards of URAC sufficient to achieve URAC accreditation or submits evidence of accreditation by URAC for its Workers' Compensation Utilization Management Standards or Health Utilization Management Standards. Nothing in this Act shall be construed to require an employer or insurer or its subcontractors to become URAC accredited.

(c) In addition, the Director ~~Secretary~~ of Insurance ~~Financial and Professional Regulation~~ may certify alternative utilization review standards of national accreditation organizations or entities in order for plans to comply with this Section. Any alternative utilization review standards shall meet or exceed those standards required under subsection (b).

(d) This registration shall include submission of all of the following information regarding utilization review program activities:

(1) The name, address, and telephone number of the utilization review programs.

(2) The organization and governing structure of the utilization review programs.

(3) The number of lives for which utilization review is conducted by each utilization review program.

(4) Hours of operation of each utilization review

program.

(5) Description of the grievance process for each utilization review program.

(6) Number of covered lives for which utilization review was conducted for the previous calendar year for each utilization review program.

(7) Written policies and procedures for protecting confidential information according to applicable State and federal laws for each utilization review program.

(e) A utilization review program shall have written procedures to ensure that patient-specific information obtained during the process of utilization review will be:

(1) kept confidential in accordance with applicable State and federal laws; and

(2) shared only with the employee, the employee's designee, and the employee's health care provider, and those who are authorized by law to receive the information. Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients or health care providers.

Only a health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.

When making retrospective reviews, utilization review programs shall base reviews solely on the medical information available to the attending physician or ordering provider at

the time the health care services were provided.

(f) If the Department of Insurance ~~Financial and Professional Regulation~~ finds that a utilization review program is not in compliance with this Section, the Department shall issue a corrective action plan and allow a reasonable amount of time for compliance with the plan. If the utilization review program does not come into compliance, the Department may issue a cease and desist order. Before issuing a cease and desist order under this Section, the Department shall provide the utilization review program with a written notice of the reasons for the order and allow a reasonable amount of time to supply additional information demonstrating compliance with the requirements of this Section and to request a hearing. The hearing notice shall be sent by certified mail, return receipt requested, and the hearing shall be conducted in accordance with the Illinois Administrative Procedure Act.

(g) A utilization review program subject to a corrective action may continue to conduct business until a final decision has been issued by the Department.

(h) The Department of Insurance ~~Secretary of Financial and Professional Regulation~~ may by rule establish a registration fee for each person conducting a utilization review program.

(i) Upon receipt of written notice that the employer or the employer's agent or insurer wishes to invoke the utilization review process, the provider of medical, surgical, or hospital services shall submit to the utilization review, following

accredited procedural guidelines.

(1) The provider shall make reasonable efforts to provide timely and complete reports of clinical information needed to support a request for treatment. If the provider fails to make such reasonable efforts, the charges for the treatment or service may not be compensable nor collectible by the provider or claimant from the employer, the employer's agent, or the employee. The reporting obligations of providers shall not be unreasonable or unduly burdensome.

(2) Written notice of utilization review decisions, including the clinical rationale for certification or non-certification and references to applicable standards of care or evidence-based medical guidelines, shall be furnished to the provider and employee.

(3) An employer may only deny payment of or refuse to authorize payment of medical services rendered or proposed to be rendered on the grounds that the extent and scope of medical treatment is excessive and unnecessary in compliance with an accredited utilization review program under this Section.

(4) When a payment for medical services has been denied or not authorized by an employer or when authorization for medical services is denied pursuant to utilization review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the

standards of care used by the person or entity performing the utilization review pursuant to subsection (a) is reasonably required to cure or relieve the effects of his or her injury.

(5) The medical professional responsible for review in the final stage of utilization review or appeal must be available in this State for interview or deposition; or must be available for deposition by telephone, video conference, or other remote electronic means. A medical professional who works or resides in this State or outside of this State may comply with this requirement by making himself or herself available for an interview or deposition in person or by making himself or herself available by telephone, video conference, or other remote electronic means. The remote interview or deposition shall be conducted in a fair, open, and cost-effective manner. The expense of interview and the deposition method shall be paid by the employer. The deponent shall be in the presence of the officer administering the oath and recording the deposition, unless otherwise agreed by the parties. Any exhibits or other demonstrative evidence to be presented to the deponent by any party at the deposition shall be provided to the officer administering the oath and all other parties within a reasonable period of time prior to the deposition. Nothing shall prohibit any party from being with the deponent during the deposition, at that party's

expense; provided, however, that a party attending a deposition shall give written notice of that party's intention to appear at the deposition to all other parties within a reasonable time prior to the deposition.

An admissible ~~A~~ utilization review shall ~~will~~ be considered by the Commission, along with all other evidence and in the same manner as all other evidence, and must be addressed along with all other evidence in the determination of the reasonableness and necessity of the medical bills or treatment. Nothing in this Section shall be construed to diminish the rights of employees to reasonable and necessary medical treatment or employee choice of health care provider under Section 8(a) or the rights of employers to medical examinations under Section 12.

(j) When an employer denies payment of or refuses to authorize payment of first aid, medical, surgical, or hospital services under Section 8(a) of this Act, if that denial or refusal to authorize complies with a utilization review program registered under this Section and complies with all other requirements of this Section, then there shall be a rebuttable presumption that the employer shall not be responsible for payment of additional compensation pursuant to Section 19(k) of this Act and if that denial or refusal to authorize does not comply with a utilization review program registered under this Section and does not comply with all other requirements of this Section, then that will be considered by the Commission, along

with all other evidence and in the same manner as all other evidence, in the determination of whether the employer may be responsible for the payment of additional compensation pursuant to Section 19(k) of this Act.

The changes to this Section made by this amendatory Act of the 97th General Assembly apply only to health care services provided or proposed to be provided on or after September 1, 2011.

(Source: P.A. 94-277, eff. 7-20-05; 94-695, eff. 11-16-05.)

(820 ILCS 305/11) (from Ch. 48, par. 138.11)

Sec. 11. The compensation herein provided, together with the provisions of this Act, shall be the measure of the responsibility of any employer engaged in any of the enterprises or businesses enumerated in Section 3 of this Act, or of any employer who is not engaged in any such enterprises or businesses, but who has elected to provide and pay compensation for accidental injuries sustained by any employee arising out of and in the course of the employment according to the provisions of this Act, and whose election to continue under this Act, has not been nullified by any action of his employees as provided for in this Act.

Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of and in the course of the employment even though the employer pays some

or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program.

Accidental injuries incurred while participating as a patient in a drug or alcohol rehabilitation program do not arise out of and in the course of employment even though the employer pays some or all of the costs thereof.

Any injury to or disease or death of an employee arising from the administration of a vaccine, including without limitation smallpox vaccine, to prepare for, or as a response to, a threatened or potential bioterrorist incident to the employee as part of a voluntary inoculation program in connection with the person's employment or in connection with any governmental program or recommendation for the inoculation of workers in the employee's occupation, geographical area, or other category that includes the employee is deemed to arise out of and in the course of the employment for all purposes under this Act. This paragraph added by this amendatory Act of the 93rd General Assembly is declarative of existing law and is not a new enactment.

No compensation shall be payable if (i) the employee's intoxication is the proximate cause of the employee's accidental injury or (ii) at the time the employee incurred the accidental injury, the employee was so intoxicated that the intoxication constituted a departure from the employment. Admissible evidence of the concentration of (1) alcohol, (2)

cannabis as defined in the Cannabis Control Act, (3) a controlled substance listed in the Illinois Controlled Substances Act, or (4) an intoxicating compound listed in the Use of Intoxicating Compounds Act in the employee's blood, breath, or urine at the time the employee incurred the accidental injury shall be considered in any hearing under this Act to determine whether the employee was intoxicated at the time the employee incurred the accidental injuries. If at the time of the accidental injuries, there was 0.08% or more by weight of alcohol in the employee's blood, breath, or urine or if there is any evidence of impairment due to the unlawful or unauthorized use of (1) cannabis as defined in the Cannabis Control Act, (2) a controlled substance listed in the Illinois Controlled Substances Act, or (3) an intoxicating compound listed in the Use of Intoxicating Compounds Act or if the employee refuses to submit to testing of blood, breath, or urine, then there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury. The employee may overcome the rebuttable presumption by the preponderance of the admissible evidence that the intoxication was not the sole proximate cause or proximate cause of the accidental injuries. Percentage by weight of alcohol in the blood shall be based on grams of alcohol per 100 milliliters of blood. Percentage by weight of alcohol in the breath shall be based upon grams of alcohol per 210 liters of breath. Any testing that has not been

performed by an accredited or certified testing laboratory shall not be admissible in any hearing under this Act to determine whether the employee was intoxicated at the time the employee incurred the accidental injury.

All sample collection and testing for alcohol and drugs under this Section shall be performed in accordance with rules to be adopted by the Commission. These rules shall ensure:

(1) compliance with the National Labor Relations Act regarding collective bargaining agreements or regulations promulgated by the United States Department of Transportation;

(2) that samples are collected and tested in conformance with national and State legal and regulatory standards for the privacy of the individual being tested, and in a manner reasonably calculated to prevent substitutions or interference with the collection or testing of reliable sample;

(3) that split testing procedures are utilized;

(4) that sample collection is documented, and the documentation procedures include:

(A) the labeling of samples in a manner so as to reasonably preclude the probability of erroneous identification of test result; and

(B) an opportunity for the employee to provide notification of any information which he or she considers relevant to the test, including

identification of currently or recently used prescription or nonprescription drugs and other relevant medical information;

(5) that sample collection, storage, and transportation to the place of testing is performed in a manner so as to reasonably preclude the probability of sample contamination or adulteration; and

(6) that chemical analyses of blood, urine, breath, or other bodily substance are performed according to nationally scientifically accepted analytical methods and procedures.

The changes to this Section made by this amendatory Act of the 97th General Assembly apply only to accidental injuries that occur on or after September 1, 2011.

(Source: P.A. 93-829, eff. 7-28-04.)

(820 ILCS 305/13) (from Ch. 48, par. 138.13)

Sec. 13. There is created an Illinois Workers' Compensation Commission consisting of 10 members to be appointed by the Governor, by and with the consent of the Senate, 3 of whom shall be representative citizens of the employing class operating under this Act and 3 of whom shall be representative citizens of the class of employees covered under this Act, and 4 of whom shall be representative citizens not identified with either the employing or employee classes. Not more than 6 members of the Commission shall be of the same political party.

One of the members not identified with either the employing or employee classes shall be designated by the Governor as Chairman. The Chairman shall be the chief administrative and executive officer of the Commission; and he or she shall have general supervisory authority over all personnel of the Commission, including arbitrators and Commissioners, and the final authority in all administrative matters relating to the Commissioners, including but not limited to the assignment and distribution of cases and assignment of Commissioners to the panels, except in the promulgation of procedural rules and orders under Section 16 and in the determination of cases under this Act.

Notwithstanding the general supervisory authority of the Chairman, each Commissioner, except those assigned to the temporary panel, shall have the authority to hire and supervise 2 staff attorneys each. Such staff attorneys shall report directly to the individual Commissioner.

A formal training program for newly-appointed Commissioners shall be implemented. The training program shall include the following:

(a) substantive and procedural aspects of the office of Commissioner;

(b) current issues in workers' compensation law and practice;

(c) medical lectures by specialists in areas such as orthopedics, ophthalmology, psychiatry, rehabilitation

counseling;

(d) orientation to each operational unit of the Illinois Workers' Compensation Commission;

(e) observation of experienced arbitrators and Commissioners conducting hearings of cases, combined with the opportunity to discuss evidence presented and rulings made;

(f) the use of hypothetical cases requiring the newly-appointed Commissioner to issue judgments as a means to evaluating knowledge and writing ability;

(g) writing skills; ~~.~~

(h) professional and ethical standards pursuant to Section 1.1 of this Act;

(i) detection of workers' compensation fraud and reporting obligations of Commission employees and appointees;

(j) standards of evidence-based medical treatment and best practices for measuring and improving quality and health care outcomes in the workers' compensation system, including but not limited to the use of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" and the practice of utilization review; and

(k) substantive and procedural aspects of coal workers' pneumoconiosis (black lung) cases.

A formal and ongoing professional development program

including, but not limited to, the above-noted areas shall be implemented to keep Commissioners informed of recent developments and issues and to assist them in maintaining and enhancing their professional competence. Each Commissioner shall complete 20 hours of training in the above-noted areas during every 2 years such Commissioner shall remain in office.

The Commissioner candidates, other than the Chairman, must meet one of the following qualifications: (a) licensed to practice law in the State of Illinois; or (b) served as an arbitrator at the Illinois Workers' Compensation Commission for at least 3 years; or (c) has at least 4 years of professional labor relations experience. The Chairman candidate must have public or private sector management and budget experience, as determined by the Governor.

Each Commissioner shall devote full time to his duties and any Commissioner who is an attorney-at-law shall not engage in the practice of law, nor shall any Commissioner hold any other office or position of profit under the United States or this State or any municipal corporation or political subdivision of this State, nor engage in any other business, employment, or vocation.

The term of office of each member of the Commission holding office on the effective date of this amendatory Act of 1989 is abolished, but the incumbents shall continue to exercise all of the powers and be subject to all of the duties of Commissioners until their respective successors are appointed and qualified.

The Illinois Workers' Compensation Commission shall administer this Act.

In the promulgation of procedural rules, the determination of cases heard en banc, and other matters determined by the full Commission, the Chairman's vote shall break a tie in the event of a tie vote.

The members shall be appointed by the Governor, with the advice and consent of the Senate, as follows:

(a) After the effective date of this amendatory Act of 1989, 3 members, at least one of each political party, and one of whom shall be a representative citizen of the employing class operating under this Act, one of whom shall be a representative citizen of the class of employees covered under this Act, and one of whom shall be a representative citizen not identified with either the employing or employee classes, shall be appointed to hold office until the third Monday in January of 1993, and until their successors are appointed and qualified, and 4 members, one of whom shall be a representative citizen of the employing class operating under this Act, one of whom shall be a representative citizen of the class of employees covered in this Act, and two of whom shall be representative citizens not identified with either the employing or employee classes, one of whom shall be designated by the Governor as Chairman (at least one of each of the two major political parties) shall be appointed

to hold office until the third Monday of January in 1991, and until their successors are appointed and qualified.

(a-5) Notwithstanding any other provision of this Section, the term of each member of the Commission who was appointed by the Governor and is in office on June 30, 2003 shall terminate at the close of business on that date or when all of the successor members to be appointed pursuant to this amendatory Act of the 93rd General Assembly have been appointed by the Governor, whichever occurs later. As soon as possible, the Governor shall appoint persons to fill the vacancies created by this amendatory Act. Of the initial commissioners appointed pursuant to this amendatory Act of the 93rd General Assembly, 3 shall be appointed for terms ending on the third Monday in January, 2005, and 4 shall be appointed for terms ending on the third Monday in January, 2007.

(a-10) After the effective date of this amendatory Act of the 94th General Assembly, the Commission shall be increased to 10 members. As soon as possible after the effective date of this amendatory Act of the 94th General Assembly, the Governor shall appoint, by and with the consent of the Senate, the 3 members added to the Commission under this amendatory Act of the 94th General Assembly, one of whom shall be a representative citizen of the employing class operating under this Act, one of whom shall be a representative of the class of employees covered

under this Act, and one of whom shall be a representative citizen not identified with either the employing or employee classes. Of the members appointed under this amendatory Act of the 94th General Assembly, one shall be appointed for a term ending on the third Monday in January, 2007, and 2 shall be appointed for terms ending on the third Monday in January, 2009, and until their successors are appointed and qualified.

(b) Members shall thereafter be appointed to hold office for terms of 4 years from the third Monday in January of the year of their appointment, and until their successors are appointed and qualified. All such appointments shall be made so that the composition of the Commission is in accordance with the provisions of the first paragraph of this Section.

The Chairman shall receive an annual salary of $42,500, or a salary set by the Compensation Review Board, whichever is greater, and each other member shall receive an annual salary of $38,000, or a salary set by the Compensation Review Board, whichever is greater.

In case of a vacancy in the office of a Commissioner during the recess of the Senate, the Governor shall make a temporary appointment until the next meeting of the Senate, when he shall nominate some person to fill such office. Any person so nominated who is confirmed by the Senate shall hold office during the remainder of the term and until his successor is

appointed and qualified.

The Illinois Workers' Compensation Commission created by this amendatory Act of 1989 shall succeed to all the rights, powers, duties, obligations, records and other property and employees of the Industrial Commission which it replaces as modified by this amendatory Act of 1989 and all applications and reports to actions and proceedings of such prior Industrial Commission shall be considered as applications and reports to actions and proceedings of the Illinois Workers' Compensation Commission created by this amendatory Act of 1989.

Notwithstanding any other provision of this Act, in the event the Chairman shall make a finding that a member is or will be unavailable to fulfill the responsibilities of his or her office, the Chairman shall advise the Governor and the member in writing and shall designate a certified arbitrator to serve as acting Commissioner. The certified arbitrator shall act as a Commissioner until the member resumes the duties of his or her office or until a new member is appointed by the Governor, by and with the consent of the Senate, if a vacancy occurs in the office of the Commissioner, but in no event shall a certified arbitrator serve in the capacity of Commissioner for more than 6 months from the date of appointment by the Chairman. A finding by the Chairman that a member is or will be unavailable to fulfill the responsibilities of his or her office shall be based upon notice to the Chairman by a member that he or she will be unavailable or facts and circumstances

made known to the Chairman which lead him to reasonably find that a member is unavailable to fulfill the responsibilities of his or her office. The designation of a certified arbitrator to act as a Commissioner shall be considered representative of citizens not identified with either the employing or employee classes and the arbitrator shall serve regardless of his or her political affiliation. A certified arbitrator who serves as an acting Commissioner shall have all the rights and powers of a Commissioner, including salary.

Notwithstanding any other provision of this Act, the Governor shall appoint a special panel of Commissioners comprised of 3 members who shall be chosen by the Governor, by and with the consent of the Senate, from among the current ranks of certified arbitrators. Three members shall hold office until the Commission in consultation with the Governor determines that the caseload on review has been reduced sufficiently to allow cases to proceed in a timely manner or for a term of 18 months from the effective date of their appointment by the Governor, whichever shall be earlier. The 3 members shall be considered representative of citizens not identified with either the employing or employee classes and shall serve regardless of political affiliation. Each of the 3 members shall have only such rights and powers of a Commissioner necessary to dispose of those cases assigned to the special panel. Each of the 3 members appointed to the special panel shall receive the same salary as other

Commissioners for the duration of the panel.

The Commission may have an Executive Director; if so, the Executive Director shall be appointed by the Governor with the advice and consent of the Senate. The salary and duties of the Executive Director shall be fixed by the Commission.

On the effective date of this amendatory Act of the 93rd General Assembly, the name of the Industrial Commission is changed to the Illinois Workers' Compensation Commission. References in any law, appropriation, rule, form, or other document: (i) to the Industrial Commission are deemed, in appropriate contexts, to be references to the Illinois Workers' Compensation Commission for all purposes; (ii) to the Industrial Commission Operations Fund are deemed, in appropriate contexts, to be references to the Illinois Workers' Compensation Commission Operations Fund for all purposes; (iii) to the Industrial Commission Operations Fund Fee are deemed, in appropriate contexts, to be references to the Illinois Workers' Compensation Commission Operations Fund Fee for all purposes; and (iv) to the Industrial Commission Operations Fund Surcharge are deemed, in appropriate contexts, to be references to the Illinois Workers' Compensation Commission Operations Fund Surcharge for all purposes.
(Source: P.A. 93-509, eff. 8-11-03; 93-721, eff. 1-1-05; 94-277, eff. 7-20-05.)

(820 ILCS 305/13.1) (from Ch. 48, par. 138.13-1)

Sec. 13.1. (a) There is created a Workers' Compensation Advisory Board hereinafter referred to as the Advisory Board. After the effective date of this amendatory Act of the 94th General Assembly, the Advisory Board shall consist of 12 members appointed by the Governor with the advice and consent of the Senate. Six members of the Advisory Board shall be representative citizens chosen from the employee class, and 6 members shall be representative citizens chosen from the employing class. The Chairman of the Commission shall serve as the ex officio Chairman of the Advisory Board. After the effective date of this amendatory Act of the 94th General Assembly, each member of the Advisory Board shall serve a term ending on the third Monday in January 2007 and shall continue to serve until his or her successor is appointed and qualified. Members of the Advisory Board shall thereafter be appointed for 4 year terms from the third Monday in January of the year of their appointment, and until their successors are appointed and qualified. Seven members of the Advisory Board shall constitute a quorum to do business, but in no case shall there be less than one representative from each class. A vacancy on the Advisory Board shall be filled by the Governor for the unexpired term.

(b) Members of the Advisory Board shall receive no compensation for their services but shall be reimbursed for expenses incurred in the performance of their duties by the Commission from appropriations made to the Commission for such

purpose.

(c) The Advisory Board shall aid the Commission in formulating policies, discussing problems, setting priorities of expenditures, reviewing advisory rates filed by an advisory organization as defined in Section 463 of the Illinois Insurance Code, and establishing short and long range administrative goals. Prior to making the (1) initial set of arbitrator appointments pursuant to this amendatory Act of the 97th General Assembly and (2) appointment of Commissioners, ~~appointments to the Commission,~~ the Governor shall request that the Advisory Board make recommendations as to candidates to consider for appointment and the Advisory Board may then make such recommendations.

(d) The terms of all Advisory Board members serving on the effective date of this amendatory Act of the 97th General Assembly are terminated. The Governor shall appoint new members to the Advisory Board within 30 days after the effective date of the amendatory Act of the 97th General Assembly, subject to the advice and consent of the Senate.

(Source: P.A. 94-277, eff. 7-20-05; 94-695, eff. 11-16-05.)

(820 ILCS 305/14) (from Ch. 48, par. 138.14)

Sec. 14. The Commission shall appoint a secretary, an assistant secretary, and arbitrators and shall employ such assistants and clerical help as may be necessary. Arbitrators shall be appointed pursuant to this Section, notwithstanding

any provision of the Personnel Code.

Each arbitrator appointed after November 22, 1977 shall be required to demonstrate in writing and in accordance with the rules and regulations of the Illinois Department of Central Management Services his or her knowledge of and expertise in the law of and judicial processes of the Workers' Compensation Act and the Occupational Diseases Act.

A formal training program for newly-hired arbitrators shall be implemented. The training program shall include the following:

(a) substantive and procedural aspects of the arbitrator position;

(b) current issues in workers' compensation law and practice;

(c) medical lectures by specialists in areas such as orthopedics, ophthalmology, psychiatry, rehabilitation counseling;

(d) orientation to each operational unit of the Illinois Workers' Compensation Commission;

(e) observation of experienced arbitrators conducting hearings of cases, combined with the opportunity to discuss evidence presented and rulings made;

(f) the use of hypothetical cases requiring the trainee to issue judgments as a means to evaluating knowledge and writing ability;

(g) writing skills; ~~.~~

(h) professional and ethical standards pursuant to Section 1.1 of this Act;

(i) detection of workers' compensation fraud and reporting obligations of Commission employees and appointees;

(j) standards of evidence-based medical treatment and best practices for measuring and improving quality and health care outcomes in the workers' compensation system, including but not limited to the use of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" and the practice of utilization review; and

(k) substantive and procedural aspects of coal workers' pneumoconiosis (black lung) cases.

A formal and ongoing professional development program including, but not limited to, the above-noted areas shall be implemented to keep arbitrators informed of recent developments and issues and to assist them in maintaining and enhancing their professional competence. Each arbitrator shall complete 20 hours of training in the above-noted areas during every 2 years such arbitrator shall remain in office.

Each arbitrator shall devote full time to his or her duties and shall serve when assigned as an acting Commissioner when a Commissioner is unavailable in accordance with the provisions of Section 13 of this Act. Any arbitrator who is an attorney-at-law shall not engage in the practice of law, nor

shall any arbitrator hold any other office or position of profit under the United States or this State or any municipal corporation or political subdivision of this State. Notwithstanding any other provision of this Act to the contrary, an arbitrator who serves as an acting Commissioner in accordance with the provisions of Section 13 of this Act shall continue to serve in the capacity of Commissioner until a decision is reached in every case heard by that arbitrator while serving as an acting Commissioner.

Notwithstanding any other provision of this Section, the term of all arbitrators serving on the effective date of this amendatory Act of the 97th General Assembly, including any arbitrators on administrative leave, shall terminate at the close of business on July 1, 2011, but the incumbents shall continue to exercise all of their duties until they are reappointed or their successors are appointed.

On and after the effective date of this amendatory Act of the 97th General Assembly, arbitrators shall be appointed to 3-year terms by the full Commission, except that initial appointments made on and after the effective date of this amendatory Act of the 97th General Assembly shall be made as follows:

(1) All appointments shall be made by the Governor with the advice and consent of the Senate.

(2) 12 arbitrators shall be appointed to terms expiring July 1, 2012; 12 arbitrators shall be appointed to terms

expiring July 1, 2013; and all additional arbitrators shall be appointed to terms expiring July 1, 2014.

Upon the expiration of a term, the Chairman shall evaluate the performance of the arbitrator and may recommend that he or she be reappointed to a second or subsequent term by the full Commission.

Each arbitrator appointed on or after the effective date of this amendatory Act of the 97th General Assembly and who has not previously served as an arbitrator for the Commission shall be required to be authorized to practice law in this State by the Supreme Court, and to maintain this authorization throughout his or her term of employment.

~~Each arbitrator appointed after the effective date of this amendatory Act of 1989 shall be appointed for a term of 6 years. Each arbitrator shall be appointed for a subsequent term unless the Chairman makes a recommendation to the Commission, no later than 60 days prior to the expiration of the term, not to reappoint the arbitrator. Notice of such a recommendation shall also be given to the arbitrator no later than 60 days prior to the expiration of the term. Upon such recommendation by the Chairman, the arbitrator shall be appointed for a subsequent term unless 8 of 10 members of the Commission, including the Chairman, vote not to reappoint the arbitrator.~~

All arbitrators shall be subject to the provisions of the Personnel Code, and the performance of all arbitrators shall be reviewed by the Chairman on an annual basis. The changes made

to this Section by this amendatory Act of the 97th General Assembly shall prevail over any conflict with the Personnel Code. The Chairman shall allow input from the Commissioners in all such reviews.

The Commission shall assign no fewer than 3 arbitrators to each hearing site. The Commission shall establish a procedure to ensure that the arbitrators assigned to each hearing site are assigned cases on a random basis. No arbitrator shall hear cases in any county, other than Cook County, for more than 2 years in each 3-year term.

The Secretary and each arbitrator shall receive a per annum salary of $4,000 less than the per annum salary of members of The Illinois Workers' Compensation Commission as provided in Section 13 of this Act, payable in equal monthly installments.

The members of the Commission, Arbitrators and other employees whose duties require them to travel, shall have reimbursed to them their actual traveling expenses and disbursements made or incurred by them in the discharge of their official duties while away from their place of residence in the performance of their duties.

The Commission shall provide itself with a seal for the authentication of its orders, awards and proceedings upon which shall be inscribed the name of the Commission and the words "Illinois--Seal".

The Secretary or Assistant Secretary, under the direction of the Commission, shall have charge and custody of the seal of

the Commission and also have charge and custody of all records, files, orders, proceedings, decisions, awards and other documents on file with the Commission. He shall furnish certified copies, under the seal of the Commission, of any such records, files, orders, proceedings, decisions, awards and other documents on file with the Commission as may be required. Certified copies so furnished by the Secretary or Assistant Secretary shall be received in evidence before the Commission or any Arbitrator thereof, and in all courts, provided that the original of such certified copy is otherwise competent and admissible in evidence. The Secretary or Assistant Secretary shall perform such other duties as may be prescribed from time to time by the Commission.

(Source: P.A. 93-721, eff. 1-1-05; 94-277, eff. 7-20-05.)

(820 ILCS 305/16b new)

Sec. 16b. Gift ban.

(a) An attorney appearing before the Commission shall not provide compensation or any gift to any person in exchange for the referral of a client involving a matter to be heard before the Commission except for a division of a fee between lawyers who are not in the same firm in accordance with Rule 1.5 of the Code of Professional Responsibility. For purposes of this Section, "gift" means any gratuity, discount, entertainment, hospitality, loan, forbearance, or any other tangible or intangible item having monetary value including, but not

limited to, cash, food and drink, and honoraria except for food or refreshments not exceeding $75 per person in value on a single calendar day, provided that the food or refreshments are (1) consumed on the premises from which they were purchased or prepared or (2) catered. "Catered" means food or refreshments that are purchased ready to eat and delivered by any means.

(b) Violation of this Section is a Class A misdemeanor.

(820 ILCS 305/18) (from Ch. 48, par. 138.18)

Sec. 18. All questions arising under this Act, if not settled by agreement of the parties interested therein, shall, except as otherwise provided, be determined by the Commission. Claims from current and former employees of the Commission shall be determined in accordance with Section 18.1 of this Act.

(Source: Laws 1951, p. 1060.)

(820 ILCS 305/18.1 new)

Sec. 18.1. Claims by former and current employees of the Commission. All claims by current and former employees and appointees of the Commission shall be assigned to a certified independent arbitrator not employed by the Commission designated by the Chairman. The Chairman shall designate an arbitrator from a list of approved certified arbitrators provided by the Commission Review Board. If the Chairman is the claimant, then the independent arbitrator from the approved

list shall be designated by the longest serving Commissioner. The designated independent arbitrator shall have the authority of arbitrators of the Commission regarding settlement and adjudication of the claim of the current and former employees and appointees of the Commission. The decision of the independent arbitrator shall become the decision of the Commission. An appeal of the independent arbitrator's decision shall be subject to judicial review in accordance with subsection (f) of Section 19.

(820 ILCS 305/19) (from Ch. 48, par. 138.19)

Sec. 19. Any disputed questions of law or fact shall be determined as herein provided.

(a) It shall be the duty of the Commission upon notification that the parties have failed to reach an agreement, to designate an Arbitrator.

1. Whenever any claimant misconceives his remedy and files an application for adjustment of claim under this Act and it is subsequently discovered, at any time before final disposition of such cause, that the claim for disability or death which was the basis for such application should properly have been made under the Workers' Occupational Diseases Act, then the provisions of Section 19, paragraph (a-1) of the Workers' Occupational Diseases Act having reference to such application shall apply.

2. Whenever any claimant misconceives his remedy and

files an application for adjustment of claim under the Workers' Occupational Diseases Act and it is subsequently discovered, at any time before final disposition of such cause that the claim for injury or death which was the basis for such application should properly have been made under this Act, then the application so filed under the Workers' Occupational Diseases Act may be amended in form, substance or both to assert claim for such disability or death under this Act and it shall be deemed to have been so filed as amended on the date of the original filing thereof, and such compensation may be awarded as is warranted by the whole evidence pursuant to this Act. When such amendment is submitted, further or additional evidence may be heard by the Arbitrator or Commission when deemed necessary. Nothing in this Section contained shall be construed to be or permit a waiver of any provisions of this Act with reference to notice but notice if given shall be deemed to be a notice under the provisions of this Act if given within the time required herein.

(b) The Arbitrator shall make such inquiries and investigations as he or they shall deem necessary and may examine and inspect all books, papers, records, places, or premises relating to the questions in dispute and hear such proper evidence as the parties may submit.

The hearings before the Arbitrator shall be held in the vicinity where the injury occurred after 10 days' notice of the

time and place of such hearing shall have been given to each of the parties or their attorneys of record.

The Arbitrator may find that the disabling condition is temporary and has not yet reached a permanent condition and may order the payment of compensation up to the date of the hearing, which award shall be reviewable and enforceable in the same manner as other awards, and in no instance be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, but shall be conclusive as to all other questions except the nature and extent of said disability.

The decision of the Arbitrator shall be filed with the Commission which Commission shall immediately send to each party or his attorney a copy of such decision, together with a notification of the time when it was filed. As of the effective date of this amendatory Act of the 94th General Assembly, all decisions of the Arbitrator shall set forth in writing findings of fact and conclusions of law, separately stated, if requested by either party. Unless a petition for review is filed by either party within 30 days after the receipt by such party of the copy of the decision and notification of time when filed, and unless such party petitioning for a review shall within 35 days after the receipt by him of the copy of the decision, file with the Commission either an agreed statement of the facts appearing upon the hearing before the Arbitrator, or if such party shall so elect a correct transcript of evidence of the

proceedings at such hearings, then the decision shall become the decision of the Commission and in the absence of fraud shall be conclusive. The Petition for Review shall contain a statement of the petitioning party's specific exceptions to the decision of the arbitrator. The jurisdiction of the Commission to review the decision of the arbitrator shall not be limited to the exceptions stated in the Petition for Review. The Commission, or any member thereof, may grant further time not exceeding 30 days, in which to file such agreed statement or transcript of evidence. Such agreed statement of facts or correct transcript of evidence, as the case may be, shall be authenticated by the signatures of the parties or their attorneys, and in the event they do not agree as to the correctness of the transcript of evidence it shall be authenticated by the signature of the Arbitrator designated by the Commission.

Whether the employee is working or not, if the employee is not receiving or has not received medical, surgical, or hospital services or other services or compensation as provided in paragraph (a) of Section 8, or compensation as provided in paragraph (b) of Section 8, the employee may at any time petition for an expedited hearing by an Arbitrator on the issue of whether or not he or she is entitled to receive payment of the services or compensation. Provided the employer continues to pay compensation pursuant to paragraph (b) of Section 8, the employer may at any time petition for an expedited hearing on

the issue of whether or not the employee is entitled to receive medical, surgical, or hospital services or other services or compensation as provided in paragraph (a) of Section 8, or compensation as provided in paragraph (b) of Section 8. When an employer has petitioned for an expedited hearing, the employer shall continue to pay compensation as provided in paragraph (b) of Section 8 unless the arbitrator renders a decision that the employee is not entitled to the benefits that are the subject of the expedited hearing or unless the employee's treating physician has released the employee to return to work at his or her regular job with the employer or the employee actually returns to work at any other job. If the arbitrator renders a decision that the employee is not entitled to the benefits that are the subject of the expedited hearing, a petition for review filed by the employee shall receive the same priority as if the employee had filed a petition for an expedited hearing by an Arbitrator. Neither party shall be entitled to an expedited hearing when the employee has returned to work and the sole issue in dispute amounts to less than 12 weeks of unpaid compensation pursuant to paragraph (b) of Section 8.

Expedited hearings shall have priority over all other petitions and shall be heard by the Arbitrator and Commission with all convenient speed. Any party requesting an expedited hearing shall give notice of a request for an expedited hearing under this paragraph. A copy of the Application for Adjustment of Claim shall be attached to the notice. The Commission shall

adopt rules and procedures under which the final decision of the Commission under this paragraph is filed not later than 180 days from the date that the Petition for Review is filed with the Commission.

Where 2 or more insurance carriers, private self-insureds, or a group workers' compensation pool under Article V 3/4 of the Illinois Insurance Code dispute coverage for the same injury, any such insurance carrier, private self-insured, or group workers' compensation pool may request an expedited hearing pursuant to this paragraph to determine the issue of coverage, provided coverage is the only issue in dispute and all other issues are stipulated and agreed to and further provided that all compensation benefits including medical benefits pursuant to Section 8(a) continue to be paid to or on behalf of petitioner. Any insurance carrier, private self-insured, or group workers' compensation pool that is determined to be liable for coverage for the injury in issue shall reimburse any insurance carrier, private self-insured, or group workers' compensation pool that has paid benefits to or on behalf of petitioner for the injury.

(b-1) If the employee is not receiving medical, surgical or hospital services as provided in paragraph (a) of Section 8 or compensation as provided in paragraph (b) of Section 8, the employee, in accordance with Commission Rules, may file a petition for an emergency hearing by an Arbitrator on the issue of whether or not he is entitled to receive payment of such

compensation or services as provided therein. Such petition shall have priority over all other petitions and shall be heard by the Arbitrator and Commission with all convenient speed.

Such petition shall contain the following information and shall be served on the employer at least 15 days before it is filed:

(i) the date and approximate time of accident;

(ii) the approximate location of the accident;

(iii) a description of the accident;

(iv) the nature of the injury incurred by the employee;

(v) the identity of the person, if known, to whom the accident was reported and the date on which it was reported;

(vi) the name and title of the person, if known, representing the employer with whom the employee conferred in any effort to obtain compensation pursuant to paragraph (b) of Section 8 of this Act or medical, surgical or hospital services pursuant to paragraph (a) of Section 8 of this Act and the date of such conference;

(vii) a statement that the employer has refused to pay compensation pursuant to paragraph (b) of Section 8 of this Act or for medical, surgical or hospital services pursuant to paragraph (a) of Section 8 of this Act;

(viii) the name and address, if known, of each witness to the accident and of each other person upon whom the employee will rely to support his allegations;

(ix) the dates of treatment related to the accident by medical practitioners, and the names and addresses of such practitioners, including the dates of treatment related to the accident at any hospitals and the names and addresses of such hospitals, and a signed authorization permitting the employer to examine all medical records of all practitioners and hospitals named pursuant to this paragraph;

(x) a copy of a signed report by a medical practitioner, relating to the employee's current inability to return to work because of the injuries incurred as a result of the accident or such other documents or affidavits which show that the employee is entitled to receive compensation pursuant to paragraph (b) of Section 8 of this Act or medical, surgical or hospital services pursuant to paragraph (a) of Section 8 of this Act. Such reports, documents or affidavits shall state, if possible, the history of the accident given by the employee, and describe the injury and medical diagnosis, the medical services for such injury which the employee has received and is receiving, the physical activities which the employee cannot currently perform as a result of any impairment or disability due to such injury, and the prognosis for recovery;

(xi) complete copies of any reports, records, documents and affidavits in the possession of the employee

on which the employee will rely to support his allegations, provided that the employer shall pay the reasonable cost of reproduction thereof;

(xii) a list of any reports, records, documents and affidavits which the employee has demanded by subpoena and on which he intends to rely to support his allegations;

(xiii) a certification signed by the employee or his representative that the employer has received the petition with the required information 15 days before filing.

Fifteen days after receipt by the employer of the petition with the required information the employee may file said petition and required information and shall serve notice of the filing upon the employer. The employer may file a motion addressed to the sufficiency of the petition. If an objection has been filed to the sufficiency of the petition, the arbitrator shall rule on the objection within 2 working days. If such an objection is filed, the time for filing the final decision of the Commission as provided in this paragraph shall be tolled until the arbitrator has determined that the petition is sufficient.

The employer shall, within 15 days after receipt of the notice that such petition is filed, file with the Commission and serve on the employee or his representative a written response to each claim set forth in the petition, including the legal and factual basis for each disputed allegation and the following information: (i) complete copies of any reports,

records, documents and affidavits in the possession of the employer on which the employer intends to rely in support of his response, (ii) a list of any reports, records, documents and affidavits which the employer has demanded by subpoena and on which the employer intends to rely in support of his response, (iii) the name and address of each witness on whom the employer will rely to support his response, and (iv) the names and addresses of any medical practitioners selected by the employer pursuant to Section 12 of this Act and the time and place of any examination scheduled to be made pursuant to such Section.

Any employer who does not timely file and serve a written response without good cause may not introduce any evidence to dispute any claim of the employee but may cross examine the employee or any witness brought by the employee and otherwise be heard.

No document or other evidence not previously identified by either party with the petition or written response, or by any other means before the hearing, may be introduced into evidence without good cause. If, at the hearing, material information is discovered which was not previously disclosed, the Arbitrator may extend the time for closing proof on the motion of a party for a reasonable period of time which may be more than 30 days. No evidence may be introduced pursuant to this paragraph as to permanent disability. No award may be entered for permanent disability pursuant to this paragraph. Either party may

introduce into evidence the testimony taken by deposition of any medical practitioner.

The Commission shall adopt rules, regulations and procedures whereby the final decision of the Commission is filed not later than 90 days from the date the petition for review is filed but in no event later than 180 days from the date the petition for an emergency hearing is filed with the Illinois Workers' Compensation Commission.

All service required pursuant to this paragraph (b-1) must be by personal service or by certified mail and with evidence of receipt. In addition for the purposes of this paragraph, all service on the employer must be at the premises where the accident occurred if the premises are owned or operated by the employer. Otherwise service must be at the employee's principal place of employment by the employer. If service on the employer is not possible at either of the above, then service shall be at the employer's principal place of business. After initial service in each case, service shall be made on the employer's attorney or designated representative.

(c) (1) At a reasonable time in advance of and in connection with the hearing under Section 19(e) or 19(h), the Commission may on its own motion order an impartial physical or mental examination of a petitioner whose mental or physical condition is in issue, when in the Commission's discretion it appears that such an examination will materially aid in the just determination of the case. The examination shall be made

by a member or members of a panel of physicians chosen for their special qualifications by the Illinois State Medical Society. The Commission shall establish procedures by which a physician shall be selected from such list.

(2) Should the Commission at any time during the hearing find that compelling considerations make it advisable to have an examination and report at that time, the commission may in its discretion so order.

(3) A copy of the report of examination shall be given to the Commission and to the attorneys for the parties.

(4) Either party or the Commission may call the examining physician or physicians to testify. Any physician so called shall be subject to cross-examination.

(5) The examination shall be made, and the physician or physicians, if called, shall testify, without cost to the parties. The Commission shall determine the compensation and the pay of the physician or physicians. The compensation for this service shall not exceed the usual and customary amount for such service.

(6) The fees and payment thereof of all attorneys and physicians for services authorized by the Commission under this Act shall, upon request of either the employer or the employee or the beneficiary affected, be subject to the review and decision of the Commission.

(d) If any employee shall persist in insanitary or injurious practices which tend to either imperil or retard his

recovery or shall refuse to submit to such medical, surgical, or hospital treatment as is reasonably essential to promote his recovery, the Commission may, in its discretion, reduce or suspend the compensation of any such injured employee. However, when an employer and employee so agree in writing, the foregoing provision shall not be construed to authorize the reduction or suspension of compensation of an employee who is relying in good faith, on treatment by prayer or spiritual means alone, in accordance with the tenets and practice of a recognized church or religious denomination, by a duly accredited practitioner thereof.

(e) This paragraph shall apply to all hearings before the Commission. Such hearings may be held in its office or elsewhere as the Commission may deem advisable. The taking of testimony on such hearings may be had before any member of the Commission. If a petition for review and agreed statement of facts or transcript of evidence is filed, as provided herein, the Commission shall promptly review the decision of the Arbitrator and all questions of law or fact which appear from the statement of facts or transcript of evidence.

In all cases in which the hearing before the arbitrator is held after December 18, 1989, no additional evidence shall be introduced by the parties before the Commission on review of the decision of the Arbitrator. In reviewing decisions of an arbitrator the Commission shall award such temporary compensation, permanent compensation and other payments as are

due under this Act. The Commission shall file in its office its decision thereon, and shall immediately send to each party or his attorney a copy of such decision and a notification of the time when it was filed. Decisions shall be filed within 60 days after the Statement of Exceptions and Supporting Brief and Response thereto are required to be filed or oral argument whichever is later.

In the event either party requests oral argument, such argument shall be had before a panel of 3 members of the Commission (or before all available members pursuant to the determination of 7 members of the Commission that such argument be held before all available members of the Commission) pursuant to the rules and regulations of the Commission. A panel of 3 members, which shall be comprised of not more than one representative citizen of the employing class and not more than one representative citizen of the employee class, shall hear the argument; provided that if all the issues in dispute are solely the nature and extent of the permanent partial disability, if any, a majority of the panel may deny the request for such argument and such argument shall not be held; and provided further that 7 members of the Commission may determine that the argument be held before all available members of the Commission. A decision of the Commission shall be approved by a majority of Commissioners present at such hearing if any; provided, if no such hearing is held, a decision of the Commission shall be approved by a majority of a

panel of 3 members of the Commission as described in this Section. The Commission shall give 10 days' notice to the parties or their attorneys of the time and place of such taking of testimony and of such argument.

In any case the Commission in its decision may find specially upon any question or questions of law or fact which shall be submitted in writing by either party whether ultimate or otherwise; provided that on issues other than nature and extent of the disability, if any, the Commission in its decision shall find specially upon any question or questions of law or fact, whether ultimate or otherwise, which are submitted in writing by either party; provided further that not more than 5 such questions may be submitted by either party. Any party may, within 20 days after receipt of notice of the Commission's decision, or within such further time, not exceeding 30 days, as the Commission may grant, file with the Commission either an agreed statement of the facts appearing upon the hearing, or, if such party shall so elect, a correct transcript of evidence of the additional proceedings presented before the Commission, in which report the party may embody a correct statement of such other proceedings in the case as such party may desire to have reviewed, such statement of facts or transcript of evidence to be authenticated by the signature of the parties or their attorneys, and in the event that they do not agree, then the authentication of such transcript of evidence shall be by the signature of any member of the Commission.

If a reporter does not for any reason furnish a transcript of the proceedings before the Arbitrator in any case for use on a hearing for review before the Commission, within the limitations of time as fixed in this Section, the Commission may, in its discretion, order a trial de novo before the Commission in such case upon application of either party. The applications for adjustment of claim and other documents in the nature of pleadings filed by either party, together with the decisions of the Arbitrator and of the Commission and the statement of facts or transcript of evidence hereinbefore provided for in paragraphs (b) and (c) shall be the record of the proceedings of the Commission, and shall be subject to review as hereinafter provided.

At the request of either party or on its own motion, the Commission shall set forth in writing the reasons for the decision, including findings of fact and conclusions of law separately stated. The Commission shall by rule adopt a format for written decisions for the Commission and arbitrators. The written decisions shall be concise and shall succinctly state the facts and reasons for the decision. The Commission may adopt in whole or in part, the decision of the arbitrator as the decision of the Commission. When the Commission does so adopt the decision of the arbitrator, it shall do so by order. Whenever the Commission adopts part of the arbitrator's decision, but not all, it shall include in the order the reasons for not adopting all of the arbitrator's decision. When

a majority of a panel, after deliberation, has arrived at its decision, the decision shall be filed as provided in this Section without unnecessary delay, and without regard to the fact that a member of the panel has expressed an intention to dissent. Any member of the panel may file a dissent. Any dissent shall be filed no later than 10 days after the decision of the majority has been filed.

Decisions rendered by the Commission and dissents, if any, shall be published together by the Commission. The conclusions of law set out in such decisions shall be regarded as precedents by arbitrators for the purpose of achieving a more uniform administration of this Act.

(f) The decision of the Commission acting within its powers, according to the provisions of paragraph (e) of this Section shall, in the absence of fraud, be conclusive unless reviewed as in this paragraph hereinafter provided. However, the Arbitrator or the Commission may on his or its own motion, or on the motion of either party, correct any clerical error or errors in computation within 15 days after the date of receipt of any award by such Arbitrator or any decision on review of the Commission and shall have the power to recall the original award on arbitration or decision on review, and issue in lieu thereof such corrected award or decision. Where such correction is made the time for review herein specified shall begin to run from the date of the receipt of the corrected award or decision.

(1) Except in cases of claims against the State of Illinois other than those claims under Section 18.1, in which case the decision of the Commission shall not be subject to judicial review, the Circuit Court of the county where any of the parties defendant may be found, or if none of the parties defendant can be found in this State then the Circuit Court of the county where the accident occurred, shall by summons to the Commission have power to review all questions of law and fact presented by such record.

A proceeding for review shall be commenced within 20 days of the receipt of notice of the decision of the Commission. The summons shall be issued by the clerk of such court upon written request returnable on a designated return day, not less than 10 or more than 60 days from the date of issuance thereof, and the written request shall contain the last known address of other parties in interest and their attorneys of record who are to be served by summons. Service upon any member of the Commission or the Secretary or the Assistant Secretary thereof shall be service upon the Commission, and service upon other parties in interest and their attorneys of record shall be by summons, and such service shall be made upon the Commission and other parties in interest by mailing notices of the commencement of the proceedings and the return day of the summons to the office of the Commission and to the last

known place of residence of other parties in interest or their attorney or attorneys of record. The clerk of the court issuing the summons shall on the day of issue mail notice of the commencement of the proceedings which shall be done by mailing a copy of the summons to the office of the Commission, and a copy of the summons to the other parties in interest or their attorney or attorneys of record and the clerk of the court shall make certificate that he has so sent said notices in pursuance of this Section, which shall be evidence of service on the Commission and other parties in interest.

The Commission shall not be required to certify the record of their proceedings to the Circuit Court, unless the party commencing the proceedings for review in the Circuit Court as above provided, shall pay to the Commission the sum of 80¢ per page of testimony taken before the Commission, and 35¢ per page of all other matters contained in such record, except as otherwise provided by Section 20 of this Act. Payment for photostatic copies of exhibit shall be extra. It shall be the duty of the Commission upon such payment, or failure to pay as permitted under Section 20 of this Act, to prepare a true and correct typewritten copy of such testimony and a true and correct copy of all other matters contained in such record and certified to by the Secretary or Assistant Secretary thereof.

In its decision on review the Commission shall determine in each particular case the amount of the probable cost of the record to be filed as a part of the summons in that case and no request for a summons may be filed and no summons shall issue unless the party seeking to review the decision of the Commission shall exhibit to the clerk of the Circuit Court proof of payment by filing a receipt showing payment or an affidavit of the attorney setting forth that payment has been made of the sums so determined to the Secretary or Assistant Secretary of the Commission, except as otherwise provided by Section 20 of this Act.

(2) No such summons shall issue unless the one against whom the Commission shall have rendered an award for the payment of money shall upon the filing of his written request for such summons file with the clerk of the court a bond conditioned that if he shall not successfully prosecute the review, he will pay the award and the costs of the proceedings in the courts. The amount of the bond shall be fixed by any member of the Commission and the surety or sureties of the bond shall be approved by the clerk of the court. The acceptance of the bond by the clerk of the court shall constitute evidence of his approval of the bond.

Every county, city, town, township, incorporated village, school district, body politic or municipal

corporation against whom the Commission shall have rendered an award for the payment of money shall not be required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons.

The court may confirm or set aside the decision of the Commission. If the decision is set aside and the facts found in the proceedings before the Commission are sufficient, the court may enter such decision as is justified by law, or may remand the cause to the Commission for further proceedings and may state the questions requiring further hearing, and give such other instructions as may be proper. Appeals shall be taken to the Appellate Court in accordance with Supreme Court Rules 22(g) and 303. Appeals shall be taken from the Appellate Court to the Supreme Court in accordance with Supreme Court Rule 315.

It shall be the duty of the clerk of any court rendering a decision affecting or affirming an award of the Commission to promptly furnish the Commission with a copy of such decision, without charge.

The decision of a majority of the members of the panel of the Commission, shall be considered the decision of the Commission.

(g) Except in the case of a claim against the State of Illinois, either party may present a certified copy of the

award of the Arbitrator, or a certified copy of the decision of the Commission when the same has become final, when no proceedings for review are pending, providing for the payment of compensation according to this Act, to the Circuit Court of the county in which such accident occurred or either of the parties are residents, whereupon the court shall enter a judgment in accordance therewith. In a case where the employer refuses to pay compensation according to such final award or such final decision upon which such judgment is entered the court shall in entering judgment thereon, tax as costs against him the reasonable costs and attorney fees in the arbitration proceedings and in the court entering the judgment for the person in whose favor the judgment is entered, which judgment and costs taxed as therein provided shall, until and unless set aside, have the same effect as though duly entered in an action duly tried and determined by the court, and shall with like effect, be entered and docketed. The Circuit Court shall have power at any time upon application to make any such judgment conform to any modification required by any subsequent decision of the Supreme Court upon appeal, or as the result of any subsequent proceedings for review, as provided in this Act.

Judgment shall not be entered until 15 days' notice of the time and place of the application for the entry of judgment shall be served upon the employer by filing such notice with the Commission, which Commission shall, in case it has on file the address of the employer or the name and address of its

agent upon whom notices may be served, immediately send a copy of the notice to the employer or such designated agent.

(h) An agreement or award under this Act providing for compensation in installments, may at any time within 18 months after such agreement or award be reviewed by the Commission at the request of either the employer or the employee, on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended.

However, as to accidents occurring subsequent to July 1, 1955, which are covered by any agreement or award under this Act providing for compensation in installments made as a result of such accident, such agreement or award may at any time within 30 months, or 60 months in the case of an award under Section 8(d)1, after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended.

On such review, compensation payments may be re-established, increased, diminished or ended. The Commission shall give 15 days' notice to the parties of the hearing for review. Any employee, upon any petition for such review being filed by the employer, shall be entitled to one day's notice for each 100 miles necessary to be traveled by him in attending the hearing of the Commission upon the petition, and 3 days in addition thereto. Such employee shall, at the discretion of the Commission, also be entitled to 5 cents per mile necessarily

traveled by him within the State of Illinois in attending such hearing, not to exceed a distance of 300 miles, to be taxed by the Commission as costs and deposited with the petition of the employer.

When compensation which is payable in accordance with an award or settlement contract approved by the Commission, is ordered paid in a lump sum by the Commission, no review shall be had as in this paragraph mentioned.

(i) Each party, upon taking any proceedings or steps whatsoever before any Arbitrator, Commission or court, shall file with the Commission his address, or the name and address of any agent upon whom all notices to be given to such party shall be served, either personally or by registered mail, addressed to such party or agent at the last address so filed with the Commission. In the event such party has not filed his address, or the name and address of an agent as above provided, service of any notice may be had by filing such notice with the Commission.

(j) Whenever in any proceeding testimony has been taken or a final decision has been rendered and after the taking of such testimony or after such decision has become final, the injured employee dies, then in any subsequent proceedings brought by the personal representative or beneficiaries of the deceased employee, such testimony in the former proceeding may be introduced with the same force and effect as though the witness having so testified were present in person in such subsequent

proceedings and such final decision, if any, shall be taken as final adjudication of any of the issues which are the same in both proceedings.

(k) In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay.

When determining whether this subsection (k) shall apply, the Commission shall consider whether an Arbitrator has determined that the claim is not compensable or whether the employer has made payments under Section 8(j).

(l) If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 ~~60~~ days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably

delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.

(m) If the commission finds that an accidental injury was directly and proximately caused by the employer's wilful violation of a health and safety standard under the Health and Safety Act in force at the time of the accident, the arbitrator or the Commission shall allow to the injured employee or his dependents, as the case may be, additional compensation equal to 25% of the amount which otherwise would be payable under the provisions of this Act exclusive of this paragraph. The additional compensation herein provided shall be allowed by an appropriate increase in the applicable weekly compensation rate.

(n) After June 30, 1984, decisions of the Illinois Workers' Compensation Commission reviewing an award of an arbitrator of the Commission shall draw interest at a rate equal to the yield on indebtedness issued by the United States Government with a 26-week maturity next previously auctioned on the day on which the decision is filed. Said rate of interest shall be set forth in the Arbitrator's Decision. Interest shall be drawn from the date of the arbitrator's award on all accrued compensation due

the employee through the day prior to the date of payments. However, when an employee appeals an award of an Arbitrator or the Commission, and the appeal results in no change or a decrease in the award, interest shall not further accrue from the date of such appeal.

The employer or his insurance carrier may tender the payments due under the award to stop the further accrual of interest on such award notwithstanding the prosecution by either party of review, certiorari, appeal to the Supreme Court or other steps to reverse, vacate or modify the award.

(o) By the 15th day of each month each insurer providing coverage for losses under this Act shall notify each insured employer of any compensable claim incurred during the preceding month and the amounts paid or reserved on the claim including a summary of the claim and a brief statement of the reasons for compensability. A cumulative report of all claims incurred during a calendar year or continued from the previous year shall be furnished to the insured employer by the insurer within 30 days after the end of that calendar year.

The insured employer may challenge, in proceeding before the Commission, payments made by the insurer without arbitration and payments made after a case is determined to be noncompensable. If the Commission finds that the case was not compensable, the insurer shall purge its records as to that employer of any loss or expense associated with the claim, reimburse the employer for attorneys' fees arising from the

challenge and for any payment required of the employer to the Rate Adjustment Fund or the Second Injury Fund, and may not reflect the loss or expense for rate making purposes. The employee shall not be required to refund the challenged payment. The decision of the Commission may be reviewed in the same manner as in arbitrated cases. No challenge may be initiated under this paragraph more than 3 years after the payment is made. An employer may waive the right of challenge under this paragraph on a case by case basis.

(p) After filing an application for adjustment of claim but prior to the hearing on arbitration the parties may voluntarily agree to submit such application for adjustment of claim for decision by an arbitrator under this subsection (p) where such application for adjustment of claim raises only a dispute over temporary total disability, permanent partial disability or medical expenses. Such agreement shall be in writing in such form as provided by the Commission. Applications for adjustment of claim submitted for decision by an arbitrator under this subsection (p) shall proceed according to rule as established by the Commission. The Commission shall promulgate rules including, but not limited to, rules to ensure that the parties are adequately informed of their rights under this subsection (p) and of the voluntary nature of proceedings under this subsection (p). The findings of fact made by an arbitrator acting within his or her powers under this subsection (p) in the absence of fraud shall be conclusive. However, the

arbitrator may on his own motion, or the motion of either party, correct any clerical errors or errors in computation within 15 days after the date of receipt of such award of the arbitrator and shall have the power to recall the original award on arbitration, and issue in lieu thereof such corrected award. The decision of the arbitrator under this subsection (p) shall be considered the decision of the Commission and proceedings for review of questions of law arising from the decision may be commenced by either party pursuant to subsection (f) of Section 19. The Advisory Board established under Section 13.1 shall compile a list of certified Commission arbitrators, each of whom shall be approved by at least 7 members of the Advisory Board. The chairman shall select 5 persons from such list to serve as arbitrators under this subsection (p). By agreement, the parties shall select one arbitrator from among the 5 persons selected by the chairman except that if the parties do not agree on an arbitrator from among the 5 persons, the parties may, by agreement, select an arbitrator of the American Arbitration Association, whose fee shall be paid by the State in accordance with rules promulgated by the Commission. Arbitration under this subsection (p) shall be voluntary.

(Source: P.A. 93-721, eff. 1-1-05; 94-277, eff. 7-20-05.)

(820 ILCS 305/25.5)

Sec. 25.5. Unlawful acts; penalties.

(a) It is unlawful for any person, company, corporation, insurance carrier, healthcare provider, or other entity to:

(1) Intentionally present or cause to be presented any false or fraudulent claim for the payment of any workers' compensation benefit.

(2) Intentionally make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining or denying any workers' compensation benefit.

(3) Intentionally make or cause to be made any false or fraudulent statements with regard to entitlement to workers' compensation benefits with the intent to prevent an injured worker from making a legitimate claim for any workers' compensation benefits.

(4) Intentionally prepare or provide an invalid, false, or counterfeit certificate of insurance as proof of workers' compensation insurance.

(5) Intentionally make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining workers' compensation insurance at less than the proper rate for that insurance.

(6) Intentionally make or cause to be made any false or fraudulent material statement or material representation on an initial or renewal self-insurance application or accompanying financial statement for the purpose of obtaining self-insurance status or reducing the amount of

security that may be required to be furnished pursuant to Section 4 of this Act.

(7) Intentionally make or cause to be made any false or fraudulent material statement to the Department ~~Division~~ of Insurance's fraud and insurance non-compliance unit in the course of an investigation of fraud or insurance non-compliance.

(8) Intentionally assist, abet, solicit, or conspire with any person, company, or other entity to commit any of the acts in paragraph (1), (2), (3), (4), (5), (6), or (7) of this subsection (a).

(9) Intentionally present a bill or statement for the payment for medical services that were not provided.

For the purposes of paragraphs (2), (3), (5), (6), ~~and~~ (7), and (9), the term "statement" includes any writing, notice, proof of injury, bill for services, hospital or doctor records and reports, or X-ray and test results.

(b) Sentences for violations of subsection (a) are as follows: ~~Any person violating subsection (a) is guilty of a Class 4 felony. Any person or entity convicted of any violation of this Section shall be ordered to pay complete restitution to any person or entity so defrauded in addition to any fine or sentence imposed as a result of the conviction.~~

(1) A violation in which the value of the property obtained or attempted to be obtained is $300 or less is a Class A misdemeanor.

(2) A violation in which the value of the property obtained or attempted to be obtained is more than $300 but not more than $10,000 is a Class 3 felony.

(3) A violation in which the value of the property obtained or attempted to be obtained is more than $10,000 but not more than $100,000 is a Class 2 felony.

(4) A violation in which the value of the property obtained or attempted to be obtained is more than $100,000 is a Class 1 felony.

(5) A person convicted under this Section shall be ordered to pay monetary restitution to the insurance company or self-insured entity or any other person for any financial loss sustained as a result of a violation of this Section, including any court costs and attorney fees. An order of restitution also includes expenses incurred and paid by the State of Illinois or an insurance company or self-insured entity in connection with any medical evaluation or treatment services.

For the purposes of this Section, where the exact value of property obtained or attempted to be obtained is either not alleged or is not specifically set by the terms of a policy of insurance, the value of the property shall be the fair market replacement value of the property claimed to be lost, the reasonable costs of reimbursing a vendor or other claimant for services to be rendered, or both. Notwithstanding the foregoing, an insurance company, self-insured entity, or any

other person suffering financial loss sustained as a result of violation of this Section may seek restitution, including court costs and attorney's fees in a civil action in a court of competent jurisdiction.

(c) The Department ~~Division~~ of Insurance ~~of the Department of Financial and Professional Regulation~~ shall establish a fraud and insurance non-compliance unit responsible for investigating incidences of fraud and insurance non-compliance pursuant to this Section. The size of the staff of the unit shall be subject to appropriation by the General Assembly. It shall be the duty of the fraud and insurance non-compliance unit to determine the identity of insurance carriers, employers, employees, or other persons or entities who have violated the fraud and insurance non-compliance provisions of this Section. The fraud and insurance non-compliance unit shall report violations of the fraud and insurance non-compliance provisions of this Section to the Special Prosecutions Bureau of the Criminal Division of the Office of the Attorney General or to the State's Attorney of the county in which the offense allegedly occurred, either of whom has the authority to prosecute violations under this Section.

With respect to the subject of any investigation being conducted, the fraud and insurance non-compliance unit shall have the general power of subpoena of the Department ~~Division~~ of Insurance, including the authority to issue a subpoena to a medical provider, pursuant to Section 8-802 of the Code of

Civil Procedure.

(d) Any person may report allegations of insurance non-compliance and fraud pursuant to this Section to the Department ~~Division~~ of Insurance's fraud and insurance non-compliance unit whose duty it shall be to investigate the report. The unit shall notify the Commission of reports of insurance non-compliance. Any person reporting an allegation of insurance non-compliance or fraud against either an employee or employer under this Section must identify himself. Except as provided in this subsection and in subsection (e), all reports shall remain confidential except to refer an investigation to the Attorney General or State's Attorney for prosecution or if the fraud and insurance non-compliance unit's investigation reveals that the conduct reported may be in violation of other laws or regulations of the State of Illinois, the unit may report such conduct to the appropriate governmental agency charged with administering such laws and regulations. Any person who intentionally makes a false report under this Section to the fraud and insurance non-compliance unit is guilty of a Class A misdemeanor.

(e) In order for the fraud and insurance non-compliance unit to investigate a report of fraud related to an employee's claim ~~by an employee~~, (i) the employee must have filed with the Commission an Application for Adjustment of Claim and the employee must have either received or attempted to receive benefits under this Act that are related to the reported fraud

or (ii) the employee must have made a written demand for the payment of benefits that are related to the reported fraud. ~~Upon receipt of a report of fraud, the employee or employer shall receive immediate notice of the reported conduct, including the verified name and address of the complainant if that complainant is connected to the case and the nature of the reported conduct. The fraud and insurance non compliance unit shall resolve all reports of fraud against employees or employers within 120 days of receipt of the report.~~ There shall be no immunity, under this Act or otherwise, for any person who files a false report or who files a report without good and just cause. Confidentiality of medical information shall be strictly maintained. Investigations that are not referred for prosecution shall be destroyed upon the expiration of the statute of limitations for the acts under investigation ~~immediately expunged~~ and shall not be disclosed except that the ~~employee or employer who was the subject of the report and the~~ person making the report shall be notified that the investigation is being closed~~, at which time the name of any complainant not connected to the case shall be disclosed to the employee or the employer~~. It is unlawful for any employer, insurance carrier, ~~or~~ service adjustment company, third party administrator, self-insured, or similar entity to file or threaten to file a report of fraud against an employee because of the exercise by the employee of the rights and remedies granted to the employee by this Act.

(e-5) The fraud and insurance non-compliance unit shall procure and implement a system utilizing advanced analytics inclusive of predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse on or before January 1, 2012. The fraud and insurance non-compliance unit shall procure this system using a request for proposals process governed by the Illinois Procurement Code and rules adopted under that Code. The fraud and insurance non-compliance unit shall provide a report to the President of the Senate, Speaker of the House of Representatives, Minority Leader of the House of Representatives, Minority Leader of the Senate, Governor, Chairman of the Commission, and Director of Insurance on or before July 1, 2012 and annually thereafter detailing its activities and providing recommendations regarding opportunities for additional fraud waste and abuse detection and prevention.

~~For purposes of this subsection (e), "employer" means any employer, insurance carrier, third party administrator, self-insured, or similar entity.~~

~~For purposes of this subsection (e), "complainant" refers to the person contacting the fraud and insurance non-compliance unit to initiate the complaint.~~

(f) Any person convicted of fraud related to workers' compensation pursuant to this Section shall be subject to the penalties prescribed in the Criminal Code of 1961 and shall be

ineligible to receive or retain any compensation, disability, or medical benefits as defined in this Act if the compensation, disability, or medical benefits were owed or received as a result of fraud for which the recipient of the compensation, disability, or medical benefit was convicted. This subsection applies to accidental injuries or diseases that occur on or after the effective date of this amendatory Act of the 94th General Assembly.

(g) Civil liability. Any person convicted of fraud who knowingly obtains, attempts to obtain, or causes to be obtained any benefits under this Act by the making of a false claim or who knowingly misrepresents any material fact shall be civilly liable to the payor of benefits or the insurer or the payor's or insurer's subrogee or assignee in an amount equal to 3 times the value of the benefits or insurance coverage wrongfully obtained or twice the value of the benefits or insurance coverage attempted to be obtained, plus reasonable attorney's fees and expenses incurred by the payor or the payor's subrogee or assignee who successfully brings a claim under this subsection. This subsection applies to accidental injuries or diseases that occur on or after the effective date of this amendatory Act of the 94th General Assembly.

(h) The ~~All proceedings under this Section shall be reported by the~~ fraud and insurance non-compliance unit shall submit a written report on an annual basis to the Chairman of the Commission, the Workers' Compensation Advisory Board, the

General Assembly, the Governor, and the Attorney General by January 1 and July 1 of each year. This report shall include, at the minimum, the following information:

(1) The number of allegations of insurance non-compliance and fraud reported to the fraud and insurance non-compliance unit.

(2) The source of the reported allegations (individual, employer, or other).

(3) The number of allegations investigated by the fraud and insurance non-compliance unit.

(4) The number of criminal referrals made in accordance with this Section and the entity to which the referral was made.

(5) All proceedings under this Section.

(Source: P.A. 94-277, eff. 7-20-05.)

(820 ILCS 305/29.1 new)

Sec. 29.1. Recalculation of premiums. On the effective date of this amendatory Act of the 97th General Assembly, the Director of Insurance shall immediately direct in writing any workers' compensation rate setting advisory organization to recalculate workers' compensation advisory premium rates and assigned risk pool premium rates so that those premiums incorporate the provisions of this amendatory Act of the 97th General Assembly, and to publish such rates on or before September 1, 2011.

(820 ILCS 305/29.2 new)

Sec. 29.2. Insurance oversight.

(a) The Department of Insurance shall annually submit to the Governor, the Chairman of the Commission, the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, and the Minority Leader of the House of Representatives a written report that details the state of the workers' compensation insurance market in Illinois. The report shall be completed by April 1 of each year, beginning in 2012, or later if necessary data or analyses are only available to the Department at a later date. The report shall be posted on the Department of Insurance's Internet website. Information to be included in the report shall be for the preceding calendar year. The report shall include, at a minimum, the following:

(1) Gross premiums collected by workers' compensation carriers in Illinois and the national rank of Illinois based on premium volume.

(2) The number of insurance companies actively engaged in Illinois in the workers' compensation insurance market, including both holding companies and subsidiaries or affiliates, and the national rank of Illinois based on number of competing insurers.

(3) The total number of insured participants in the Illinois workers' compensation assigned risk insurance

pool, and the size of the assigned risk pool as a proportion of the total Illinois workers' compensation insurance market.

(4) The advisory organization premium rate for workers' compensation insurance in Illinois for the previous year.

(5) The advisory organization prescribed assigned risk pool premium rate.

(6) The total amount of indemnity payments made by workers' compensation insurers in Illinois.

(7) The total amount of medical payments made by workers' compensation insurers in Illinois, and the national rank of Illinois based on average cost of medical claims per injured worker.

(8) The gross profitability of workers' compensation insurers in Illinois, and the national rank of Illinois based on profitability of workers' compensation insurers.

(9) The loss ratio of workers' compensation insurers in Illinois and the national rank of Illinois based on the loss ratio of workers' compensation insurers. For purposes of this loss ratio calculation, the denominator shall include all premiums and other fees collected by workers' compensation insurers and the numerator shall include the total amount paid by the insurer for care or compensation to injured workers.

(10) The growth of total paid indemnity benefits by

temporary total disability, scheduled and non-scheduled permanent partial disability, and total disability.

(11) The number of injured workers receiving wage loss differential awards and the average wage loss differential award payout.

(12) Illinois' rank, relative to other states, for:

(i) the maximum and minimum temporary total disability benefit level;

(ii) the maximum and minimum scheduled and non-scheduled permanent partial disability benefit level;

(iii) the maximum and minimum total disability benefit level; and

(iv) the maximum and minimum death benefit level.

(13) The aggregate growth of medical benefit payout by non-hospital providers and hospitals.

(14) The aggregate growth of medical utilization for the top 10 most common injuries to specific body parts by non-hospital providers and hospitals.

(15) The percentage of injured workers filing claims at the Commission that are represented by an attorney.

(16) The total amount paid by injured workers for attorney representation.

(b) The Director of Insurance shall promulgate rules requiring each insurer licensed to write workers' compensation coverage in the State to record and report the following

information on an aggregate basis to the Department of Insurance before March 1 of each year, relating to claims in the State opened within the prior calendar year:

(1) The number of claims opened.

(2) The number of reported medical only claims.

(3) The number of contested claims.

(4) The number of claims for which the employee has attorney representation.

(5) The number of claims with lost time and the number of claims for which temporary total disability was paid.

(6) The number of claim adjusters employed to adjust workers' compensation claims.

(7) The number of claims for which temporary total disability was not paid within 14 days from the first full day off, regardless of reason.

(8) The number of medical bills paid 60 days or later from date of service and the average days paid on those paid after 60 days for the previous calendar year.

(9) The number of claims in which in-house defense counsel participated, and the total amount spent on in-house legal services.

(10) The number of claims in which outside defense counsel participated, and the total amount paid to outside defense counsel.

(11) The total amount billed to employers for bill review.

(12) The total amount billed to employers for fee schedule savings.

(13) The total amount charged to employers for any and all managed care fees.

(14) The number of claims involving in-house medical nurse case management, and the total amount spent on in-house medical nurse case management.

(15) The number of claims involving outside medical nurse case management, and the total amount paid for outside medical nurse case management.

(16) The total amount paid for Independent Medical exams.

(17) The total amount spent on in-house Utilization Review for the previous calendar year.

(18) The total amount paid for outside Utilization Review for the previous calendar year.

The Department shall make the submitted information publicly available on the Department's Internet website or such other media as appropriate in a form useful for consumers.

Section 97. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

Section 99. Effective date. This Act takes effect upon becoming law.