AN ACT concerning employment.

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

Section 5. The Illinois Insurance Code is amended by changing Sections 456, 457, and 458 and by adding Section 462a as follows:

(215 ILCS 5/456) (from Ch. 73, par. 1065.3)

Sec. 456. Making of rates. (1) All rates shall be made in accordance with the following provisions:

(a) Due consideration shall be given to past and prospective loss experience within and outside this state, to catastrophe hazards, if any, to a reasonable margin for profit and contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers, to past and prospective expenses both countrywide and those specially applicable to this state, to underwriting practice and judgment and to all other relevant factors within and outside this state;

(b) The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the requirements of the operating methods of any such company or group with respect to any kind of insurance, or with respect to
any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable;

(c) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which measure variation in hazards or expense provisions, or both. Such rating plans may measure any differences among risks that have a probable effect upon losses or expenses;

(d) Rates shall not be excessive, inadequate or unfairly discriminatory.

A rate in a competitive market is not excessive. A rate in a noncompetitive market is excessive if it is likely to produce a long-run profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to the services rendered.

A rate is not inadequate unless such rate is clearly insufficient to sustain projected losses and expenses in the class of business to which it applies and the use of such rate has or, if continued, will have the effect of substantially lessening competition or the tendency to create monopoly in any market.

Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums
result for policyholders with like exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

(e) The rating plan shall contain a mandatory offer of a deductible applicable only to the medical benefit under the Workers' Compensation Act. Such deductible offer shall be in a minimum amount of at least $1,000 per accident.

(f) Any rating plan or program shall include a rule permitting 2 or more employers with similar risk characteristics, who participate in a loss prevention program or safety group, to pool their premium and loss experience in determining their rate or premium for such participation in the program.

(2) Except to the extent necessary to meet the provisions of subdivision (d) of subsection (1) of this Section, uniformity among companies in any matters within the scope of this Section is neither required nor prohibited.

(Source: P.A. 82-939.)

(215 ILCS 5/457) (from Ch. 73, par. 1065.4)

Sec. 457. Rate filings. (1) Every Beginning January 1, 1983, every company shall file with the Director every manual of classifications, every manual of rules and rates, every rating plan and every modification of the foregoing which it intends to use. Such filings shall be made at least
later than 30 days before after they become effective. A company may satisfy its obligation to make such filings by adopting the filing of a licensed rating organization of which it is a member or subscriber, filed pursuant to subsection (2) of this Section, in total or, with the approval of the Director, by notifying the Director in what respects it intends to deviate from such filing. **If a company intends to deviate from the filing of a licensed rating organization of which it is a member, the company shall provide the Director with supporting information that specifies the basis for the requested deviation and provides justification for the deviation.** Any company adopting a pure premium filed by a rating organization pursuant to subsection (2) must file with the Director the modification factor it is using for expenses and profit so that the final rates in use by such company can be determined.

(2) **Each Beginning January 1, 1983, each licensed rating organization must file** with the Director every manual of classification, every manual of rules and advisory rates, every pure premium which has been fully adjusted and fully developed, every rating plan and every modification of any of the foregoing which it intends to recommend for use to its members and subscribers, **at least not later than 30 days before after such manual, premium, plan or modification thereof takes effect.** Every licensed rating organization shall also file with the Director the rate classification system, all rating rules,
rating plans, policy forms, underwriting rules or similar materials, and each modification of any of the foregoing which it requires its members and subscribers to adhere to not later than 30 days before such filings or modifications thereof are to take effect. Every such filing shall state the proposed effective date thereof and shall indicate the character and extent of the coverage contemplated.

(3) A filing and any supporting information made pursuant to this Section shall be open to public inspection as soon as filed after the filing becomes effective.

(4) A filing shall not be effective nor used until approved by the Director. A filing shall be deemed approved if the Director fails to disapprove within 30 days after the filing.

(Source: P.A. 82-939.)

(215 ILCS 5/458) (from Ch. 73, par. 1065.5)

Sec. 458. Disapproval of filings. (1) If within 30 thirty days of any filing the Director finds that such filing does not meet the requirements of this Article, he shall send to the company or rating organization which made such filing a written notice of disapproval of such filing, specifying therein in what respects he finds that such filing fails to meet the requirements of this Article and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. A company or rating organization whose filing has been disapproved shall be given a hearing upon a written
request made within 30 days after the disapproval order. If the company or rating organization making the filing shall, prior to the expiration of the period prescribed in the notice, request a hearing, such filings shall be effective until the expiration of a reasonable period specified in any order entered thereon. If the rate resulting from such filing be unfairly discriminatory or materially inadequate, and the difference between such rate and the approved rate equals or exceeds the cost of making an adjustment, the Director shall in such notice or order direct an adjustment of the premium to be made with the policyholder either by refund or collection of additional premium. If the policyholder does not accept the increased rate, cancellation shall be made on a pro rata basis. Any policy issued pursuant to this subsection shall contain a provision that the premium thereon shall be subject to adjustment upon the basis of the filing finally approved.

(2) If at any time subsequent to the applicable review period provided for in subsection (1) of this Section, the Director finds that a filing does not meet the requirements of this Article, he shall, after a hearing held upon not less than ten days written notice, specifying the matters to be considered at such hearing, to every company and rating organization which made such filing, issue an order specifying in what respects he finds that such filing fails to meet the requirements of this Article, and stating when, within a reasonable period thereafter, such filings shall be deemed no
longer effective. Copies of said order shall be sent to every such company and rating organization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order.

(3) Any person or organization aggrieved with respect to any filing which is in effect may make written application to the Director for a hearing thereon, provided, however, that the company or rating organization that made the filing shall not be authorized to proceed under this subsection. Such application shall specify the grounds to be relied upon by the applicant. If the Director shall find that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise justify holding such a hearing, he shall, within thirty days after receipt of such application, hold a hearing upon not less than ten days written notice to the applicant and to every company and rating organization which made such filing.

If, after such hearing, the Director finds that the filing does not meet the requirements of this Article, he shall issue an order specifying in what respects he finds that such filing fails to meet the requirements of this Article, and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Copies of said order shall be sent to the applicant and to every such company and rating organization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set
forth in said order.

(4) Whenever an insurer has no legally effective rates as a result of the Director's disapproval of rates or other act, the Director shall on request of the insurer specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by him or her. When new rates become legally effective, the Director shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis shall not be required.

(Source: P.A. 82-939.)

(215 ILCS 5/462a new)

Sec. 462a. Premiums; review.

(a) Premiums shall not be excessive. A premium is excessive if it is likely to produce a profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to the coverage or services rendered.

(b) At any time, an insured may file a request for review of a premium with the Director. The request shall be in such form as the Director prescribes and shall specify the grounds on which the premium is excessive.

If, within 30 days of any proper request for review under this Section, the Director finds that the premium does not meet the requirements of this Section, he or she shall send to the
insurer a written notice of disapproval of premium, specifying therein in what respects he or she finds that the premium fails to meet the requirements of this Section, stating when, within a reasonable period thereafter, the premium shall be deemed no longer effective, and ordering an adjustment of the premium. An insurer whose premium has been disapproved shall be given a hearing upon a written request made within 30 days after the disapproval order. If the insurer requests a hearing, the premium shall be effective until the expiration of a reasonable period specified in any order entered thereon. If, after a hearing, the premium is found to be excessive, the Director shall order an adjustment of the premium. The insurer shall refund to the insured any amount found to be excessive under this Section.

If the Director finds that a review is not warranted or a premium is not excessive, he or she shall provide notice of that decision to the insured and the insurer.

(c) An insurer shall provide all information requested by the Director as he or she determines necessary to assist in review of premiums under this Section.

(215 ILCS 5/460 rep.)

Section 10. The Illinois Insurance Code is amended by repealing Section 460.

Section 15. The Workers' Compensation Act is amended by
changing Sections 1, 8, 8.1b, 8.2, 8.2a, 14, 19, 25.5, and 29.2
and by adding Sections 4e, 8.1, and 29.3 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 500,000 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 500,000 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. Except as provided in subsection (e) of this Section, accidental injuries sustained while traveling to or from work do not arise out of and in the course of employment.

For the purposes of this subsection (d):

"In the course of employment" refers to the time, place, and circumstances surrounding the accidental injuries.

"Arising out of the employment" refers to causal connection. It must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injuries. An injury arises out of the employment if, at the time of the occurrence, the employee was performing acts he or she was instructed to perform by his or her employer, acts which he or she had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his or her assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his or her duties.

(e) Where an employee is required to travel away from his
or her employer's premises in order to perform his or her job, the traveling employee's accidental injuries arise out of his or her employment, and are in the course of his or her employment, when the conduct in which he or she was engaged at the time of the injury is reasonable and when that conduct might have been anticipated or foreseen by the employer. Accidental injuries while traveling do not occur in the course of employment if the accident occurs during a purely personal deviation or personal errand unless such deviation or errand is insubstantial.

In determining whether an employee was required to travel away from his or her employer's premises in order to perform his or her job, along with all other relevant factors, the following factors may be considered: whether the employer had knowledge that the employee may be required to travel to perform the job; whether the employer furnished any mode of transportation to or from the employee; whether the employee received, or the employer paid or agreed to pay, any remuneration or reimbursement for costs or expenses of any form of travel; whether the employer in any way directed the course or method of travel; whether the employer in any way assisted the employee in making any travel arrangements; whether the employer furnished lodging or in any way reimbursed the employee for lodging; and whether the employer received any benefit from the employee traveling.

(Source: P.A. 97-18, eff. 6-28-11; 97-268, eff. 8-8-11; 97-813,
Sec. 4e. Safety programs and return to work programs; recalculation of premiums and waiver of self-insurers fee.

(a) An employer may file with the Commission a workers' compensation safety program or a workers' compensation return to work program implemented by the employer. The Commission may certify any such safety program as a bona fide safety program after reviewing the program for the following minimum requirements: adequate safety training for employees; establishment of joint employer-employee safety committees; use of safety devices; and consultation with safety organizations. The Commission may certify any such return to work program as a bona fide return to work program after reviewing the program for the following minimum requirements: light duty or restricted duty work; leave of absence policy; and full duty return to work policy. The Commission shall notify the Department of Insurance of the certification.

(b) Upon receipt of a certification notice from the Commission under this Section related to an employer that provides workers' compensation through an insurer, the Director of Insurance shall immediately direct in writing the employer's workers' compensation insurer to recalculate the workers' compensation premium rates for the employer so that those premium rates incorporate and take into account the
certified program.

(c) If any workers' compensation safety program or a workers' compensation return to work program implemented by a self-insured employer is certified under this Section, the annual fee under Section 4d of this Act shall be reduced by 30% for the self-insured employer as long as the workers' compensation safety program or a workers' compensation return to work program continues. The self-insured employer shall certify the continuation of the program by each July 1 after the waiver is obtained.

(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 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 June 28, 2011 (the effective date of Public Act 97-18) 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. The foregoing
notwithstanding, in the case of an employee who is employed as
a volunteer, paid-on-call, or part-time firefighter, emergency medical technician, or paramedic or 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 500,000 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.

190 weeks if the accidental injury occurs on or after June 28, 2011 (the effective date of Public Act 97-18) 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.

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.

For purposes of awards under this subdivision (e), injuries to the shoulder shall be considered injuries to part of the arm.

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.

For purposes of awards under this subdivision (e), injuries to the hip shall be considered injuries to part of the leg.
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:

<table>
<thead>
<tr>
<th>Sound Level DBA</th>
<th>Slow Response</th>
<th>Hours Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>8</td>
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</tr>
<tr>
<td>92</td>
<td>6</td>
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<td>97</td>
<td>3</td>
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<tr>
<td>100</td>
<td>2</td>
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</tr>
<tr>
<td>102</td>
<td>1-1/2</td>
<td></td>
</tr>
<tr>
<td>105</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>110</td>
<td>1/2</td>
<td></td>
</tr>
<tr>
<td>115</td>
<td>1/4</td>
<td></td>
</tr>
</tbody>
</table>

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, or loss under Section 8(d)2 due to accidental injuries to the same part of the spine, such loss or partial loss of any such member or loss under Section 8(d)2 due to accidental injuries to the same part of the spine 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 or loss under Section 8(d)2 due to accidental injuries to the same part of the spine, for which compensation has been paid, then such loss shall be taken into consideration and deducted from any award for the subsequent injury. For purposes of this subdivision (e)17 only, "same part of the spine" means: (1) cervical spine and thoracic spine from vertebra C1 through T12 and (2) lumbar and sacral spine and coccyx from vertebra L1 through S5.

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. 97-18, eff. 6-28-11; 97-268, eff. 8-8-11; 97-813, eff. 7-13-12.)

(820 ILCS 305/8.1 new)

Sec. 8.1. Repetitive and cumulative injuries; right of contribution.

(a) Any accidental injury which results from repetitive or cumulative trauma and occurs within 3 months after the employee
begins his or her employment shall not be considered by a workers' compensation insurer in setting the premium rate for the employer.

(b) If an award is made for benefits in connection with repetitive or cumulative injury resulting from employment with more than one employer, the employer liable for award or its insurer is entitled to contributions or reimbursement from each of the employee's prior employers which are subject to this Act or their insurers for the prior employer's pro rata share of responsibility as determined by the Commission. The right to contribution or reimbursement under this Section shall not delay, diminish, restrict, or alter in any way the benefits to which the employee or his or her dependents are entitled under this Act. At any time within one year after the Commission or the Arbitrator has made an award for benefits in connection with repetitive or cumulative injury, the employer liable under the award or its insurer may institute proceedings before the Commission for the purpose of determining the right of contribution or reimbursement. The proceeding shall not delay, diminish, restrict, or alter in any way the benefits to which the employee or his or her dependents are entitled under this Act, but shall be limited to a determination of the respective contribution or reimbursement rights and the responsibilities of all the employers joined in the proceeding. The employee has the duty of rendering reasonable cooperation in any of such proceeding.
(c) No contribution or reimbursement may be sought for any payment of benefits more than 2 years after the employer seeking contribution or reimbursement has made the payment.

(d) This Section shall apply only to injuries occurring on or after the effective date of this amendatory Act of the 100th General Assembly.

(e) The Commission shall adopt emergency rules under Section 5-45 of the Illinois Administrative Procedure Act to implement the provisions of this Section to implement this Section.

(820 ILCS 305/8.1b)

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) if such a report exists and is
admitted into evidence; (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 or examination under Section 12 of this Act. Where an
impairment report exists and is admitted into evidence, it must
be considered by the Commission in its determination. 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.

(c) A report of impairment prepared pursuant to subsection
(a) is not required for an arbitrator or the Commission to make
an award for permanent partial disability or permanent total
disability benefits or any award for benefits under subsection
(c) of Section 8 or subsection (d) of Section 8 of this Act or
to approve a Settlement Contract Lump Sum Petition.

(Source: P.A. 97-18, eff. 6-28-11.)
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. 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.

(a-4) The Commission, in consultation with the Workers’ Compensation Medical Fee Advisory Board, shall promulgate by rule an evidence-based drug formulary and any rules necessary for its administration. Prescriptions prescribed for workers’ compensation cases shall be limited to those prescription and non-prescription drugs and doses on the closed formulary. A request for a prescription that is not on the closed formulary shall be reviewed pursuant to Section 8.7 of this Act.

(a-5) Notwithstanding any other provision of this Section, on or before March 1, 2018 and on or before March 1 of each subsequent year, the Commission must investigate all procedures, treatments, and services covered under this Act for ambulatory surgical treatment centers and accredited ambulatory surgical treatment facilities and establish fee schedule amounts for procedures, treatments, and services for which fee schedule amounts have not been established. The Commission must adopt, in a timely and ongoing manner, all rules necessary to ensure that its responsibilities under this subsection are carried out.
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 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
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. 97-18, eff. 6-28-11.)

(820 ILCS 305/8.2a)

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.

(4) Ensure that health care providers have at least 15 business days to comply with records requested by employers and insurers for the authorization of the payment of
workers' compensation claims.

(5) Ensure that health care providers are responsible for supplying only those medical records pertaining to the provider's own claims that are minimally necessary under the federal Health Insurance Portability and Accountability Act of 1996.

(6) Provide that any electronically submitted bill determined to be complete but not paid or objected to within 30 days shall be subject to penalties pursuant to Section 8.2(d)(3) of this Act to be entered by the Commission.

(7) Provide that the Department of Insurance shall impose an administrative fine if it determines that an employer or insurer has failed to comply with the electronic claims acceptance and response process. The amount of the administrative fine shall be no greater than $1,000 per each violation, but shall not exceed $10,000 for identical violations during a calendar year.

(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. The Director of
Insurance shall adopt rules by June 30, 2017 to implement the
changes to this Section made by this amendatory Act of the
100th General Assembly. The Commission, with assistance from
the Department and the Medical Fee Advisory Board, shall
publish on its Internet website a companion guide to assist
with compliance with electronic claims rules. The Medical Fee
Advisory Board shall periodically review the companion guide.

(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.

(Source: P.A. 97-18, eff. 6-28-11.)

(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 June 28, 2011 shall be
required to demonstrate in writing his or her knowledge of and
expertise in the law of and judicial processes of the Workers' Compensa-
Compensation Act and the Workers' 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 June 28, 2011 (the effective date of Public Act 97-18), 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 June 28, 2011 (the effective date of Public Act 97-18), arbitrators shall be appointed to 3-year terms as follows:

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

(2) For their initial appointments, 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. Thereafter, all arbitrators shall be appointed to 3-year terms.

Upon the expiration of a term, the Chairman shall evaluate the performance of the arbitrator and may recommend to the Governor that he or she be reappointed to a second or subsequent term by the Governor with the advice and consent of the Senate.

Each arbitrator appointed on or after June 28, 2011 (the effective date of Public Act 97-18) 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.

The performance of all arbitrators shall be reviewed by the Chairman on an annual basis. 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. **The Chairman of the Commission shall have discretion to assign and reassign arbitrators to each hearing sites as needed.** 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. 98-40, eff. 6-28-13; 99-642, eff. 7-28-16.)

(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;

(xii) 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;

(xiii) 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 file with the
Commission notice of intent to file for review in Circuit
Court. It shall be the duty of the Commission upon such filing of notice of intent to file for review in the Circuit Court to prepare a true and correct 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. The changes made to this subdivision (f)(1) by this amendatory Act of the 98th General Assembly apply to any Commission decision entered after the effective date of this amendatory Act of the 98th General Assembly.

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 filing with the Commission of the notice of the intent to file for review in the Circuit Court or an affidavit of the attorney setting forth that notice of intent to file for review in the Circuit Court has been given in writing to the Secretary or Assistant Secretary of the Commission.

(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.

The State of Illinois, including its constitutional officers, boards, commissions, agencies, public institutions of higher learning, and funds administered by the treasurer ex officio, and 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).

(k-1) In a case where there has been unreasonable or vexatious delay of authorization of medical treatment, the Commission may award compensation additional to that otherwise payable under this Act in the sum of $30 per day for each day that the benefits under Section 8(a) have been so withheld or refused, not to exceed $10,000 or the total amount due per Section 8.2 for treatment to be rendered whichever is less.

Unless utilization review under Section 8.7 or Section 12 examination is, or has been, requested, a delay in authorization of 14 days or more from the employer's receipt of all appropriate records and data elements needed to allow the employer to make a determination whether to authorize such care shall create a rebuttable presumption of unreasonable delay.

This subsection (k-1) is the only penalty provision within the Act applicable to delay of authorization of medical treatment and shall apply only to health care services provided or proposed to be provided on or after the effective date of this amendatory Act of the 100th General Assembly.

(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 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 or the Occupational Safety and Health 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. 97-18, eff. 6-28-11; 98-40, eff. 6-28-13; 98-874, eff. 1-1-15.)
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 amount 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 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), (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:

(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.

(4.5) A violation of paragraph (3), (4), or (7) of subsection (a) in which the offender did not attempt to obtain any workers' compensation benefits or other property of value is a Class A misdemeanor.

(4.7) A violation of paragraph (8) of subsection (a) shall be subject to the same penalty as the offense to which the offender assisted, abetted, solicited, or conspired.

(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 of Insurance 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 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 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, (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. 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 and shall not be disclosed except that the person making the report shall be notified that the investigation is being closed. It is unlawful for any employer, insurance carrier, 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.

(e-7) By July 1, 2017 and thereafter, the fraud and insurance non-compliance unit shall employ at least 10 investigators to investigate insurance non-compliance and fraud pursuant to this Section.

(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 2012 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 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. 97-18, eff. 6-28-11; 97-1150, eff. 1-25-13.)

(820 ILCS 305/29.2)

Sec. 29.2. Insurance and self-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.


(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.

(a-5) The Commission shall annually submit to the Governor and the General Assembly a written report that details the state of self-insurance for workers' compensation in Illinois. The report shall be based on the types of information collected by the Commission or the Department of Insurance from self-insurers, as of the effective date of this amendatory Act of the 100th General Assembly. The report shall be completed by April 1 of each year, beginning in 2017. The report shall be posted on the Commission'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 in the aggregate:

(1) The number of employers that self-insure for workers' compensation;

(2) The total number of employees covered by self-insurance;

(3) The total amount of indemnity payments made by self-insureds;

(4) The total number of claims on which indemnity payments were made by self-insureds;

(5) The total amount of medical payments made by
self-insureds;

(6) The total number of claims on which medical payments were made by self-insureds;

(7) The total number of claims on which both indemnity and medical payments were made by self-insureds;

(8) The median of the injured workers' weekly wage of self-insureds employees;

(9) The growth of total paid indemnity benefits by temporary total disability, scheduled and non-scheduled permanent partial disability, and total disability;

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

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

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

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

(iv) the maximum and minimum death benefit levels; and

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

(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.

(Source: P.A. 97-18, eff. 6-28-11.)

(820 ILCS 305/29.3 new)

Sec. 29.3. Workers' Compensation Premium Rates Task Force.

(a) There is created the Workers' Compensation Premium Rates Task Force consisting of 12 members appointed as follows:

2 legislative members appointed by the Speaker of the House of Representatives; 2 legislative members appointed by the
Minority Leader of the House of Representatives; 2 legislative members appointed by the President of the Senate; 2 legislative members appointed by the Minority Leader of the Senate; and one member appointed by the Governor from each of the following organizations: (i) a statewide association representing retailers; (ii) a statewide association representing manufacturers; (iii) a statewide association representing labor interests; and (iv) a statewide association representing injured workers. The members of the Task Force shall be appointed by April 1, 2017. Two co-chairpersons, representing different political parties, shall be selected by the members of the Task Force. Members of the Task Force shall receive no compensation for their service on the Task Force.

(b) The Task Force shall study the National Council on Compensation Insurance's recommendations for workers' compensation premium rates, the extent to which Illinois employers' actual premiums reflect these recommended rates. The Task Force shall also study the feasibility of establishing a competitive nonprofit, independent public corporation to provide workers' compensation insurance and the impact that the corporation would have on insurance rates and premiums. The Department of Insurance shall provide administrative support to the Task Force.

(c) The Task Force shall report its findings and recommendations to the General Assembly no later than December 31, 2017.
(d) This Section is repealed December 31, 2018.

Section 99. Effective date. This Act takes effect upon becoming law.
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<td>215 ILCS 5/456 from Ch. 73, par. 1065.3</td>
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<td>215 ILCS 5/458 from Ch. 73, par. 1065.5</td>
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<td>215 ILCS 5/460 rep.</td>
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<td>8</td>
<td>820 ILCS 305/1 from Ch. 48, par. 138.1</td>
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<td>820 ILCS 305/4e new</td>
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