HB4493

LRB10222845BMS31996b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB4493

Introduced 1/21/2022, by Rep. Bob Morgan

SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Insurance Code. In provisions concerning uninsured motor vehicle coverage, provides that no motor vehicle insurance policy shall be renewed, delivered, or issued in the State unless coverage is made available in the amount of the cash value of the motor vehicle or the limit for uninsured motor vehicle property damage (rather than $15,000), whichever is less. In provisions concerning fraud reporting, provides that the Director of Insurance may request an insurer to report factual information that is pertinent to suspected insurance fraud after a determination that the information is necessary to detect fraud or arson. Removes language providing that the Director is authorized to establish fraud reporting requirements by rule. In provisions concerning standard non-forfeiture for individual deferred annuities, changes an interest rate to 0.15% (rather than 1%). Sets forth provisions concerning availability of information on qualified health plans. In provisions concerning refunds, penalties, and collection, provides that the Department of Insurance shall deposit an amount of cash refunds approved by the Director (rather than an amount calculated by using an annual percentage) into the Insurance Premium Tax Refund Fund. Repeals a provision concerning preexisting condition exclusions. Makes other changes. Makes conforming changes in the Health Maintenance Organization Act, the Limited Health Service Organization Act, and the Voluntary Health Services Plans Act. Amends the Illinois Health Insurance Portability and Accountability Act. Provides that no health insurance coverage issued, amended, delivered, or renewed on or after the effective date of the amendatory Act may impose any preexisting condition exclusion with respect to the plan or coverage. Removes language concerning preexisting condition exclusion limitations. Amends the Workers' Compensation Act. In provisions concerning decisions of the Industrial Commission, provides that the State of Illinois shall not be required to file a bond to secure payment of an award for payment of money and the costs of proceedings in the court to authorize the circuit court to issue summons. Amends the Unemployment Insurance Act. Provides that the Director may make available to the Department of Insurance information regarding employers for the purpose of verifying insurance coverage. Effective immediately.

A BILL FOR

AN ACT concerning regulation.

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 143a, 155.23, 229.4a, 353a, 355a, and 412 and by adding Section 355c as follows:

(215 ILCS 5/143a) (from Ch. 73, par. 755a)

Sec. 143a. Uninsured and hit and run motor vehicle coverage.

(1) No policy insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out of the ownership, maintenance or use of a motor vehicle that is designed for use on public highways and that is either required to be registered in this State or is principally garaged in this State shall be renewed, delivered, or issued for delivery in this State unless coverage is provided therein or supplemental thereto, in limits for bodily injury or death set forth in Section 7-203 of the Illinois Vehicle Code for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles and hit-and-run motor vehicles because of bodily injury, sickness or disease, including death, resulting therefrom. Uninsured

motor vehicle coverage does not apply to bodily injury, sickness, disease, or death resulting therefrom, of an insured while occupying a motor vehicle owned by, or furnished or available for the regular use of the insured, a resident spouse or resident relative, if that motor vehicle is not described in the policy under which a claim is made or is not a newly acquired or replacement motor vehicle covered under the terms of the policy. The limits for any coverage for any vehicle under the policy may not be aggregated with the limits for any similar coverage, whether provided by the same insurer or another insurer, applying to other motor vehicles, for purposes of determining the total limit of insurance coverage available for bodily injury or death suffered by a person in any one accident. No policy shall be renewed, delivered, or issued for delivery in this State unless it is provided therein that any dispute with respect to the coverage and the amount of damages shall be submitted for arbitration to the American Arbitration Association and be subject to its rules for the conduct of arbitration hearings as to all matters except medical opinions. As to medical opinions, if the amount of damages being sought is equal to or less than the amount provided for in Section 7-203 of the Illinois Vehicle Code, then the current American Arbitration Association Rules shall apply. If the amount being sought in an American Arbitration Association case exceeds that amount as set forth in Section 7-203 of the Illinois Vehicle Code, then the Rules of Evidence

that apply in the circuit court for placing medical opinions into evidence shall govern. Alternatively, disputes with respect to damages and the coverage shall be determined in the following manner: Upon the insured requesting arbitration, each party to the dispute shall select an arbitrator and the 2 arbitrators so named shall select a third arbitrator. If such arbitrators are not selected within 45 days from such request, either party may request that the arbitration be submitted to the American Arbitration Association. Any decision made by the arbitrators shall be binding for the amount of damages not exceeding $75,000 for bodily injury to or death of any one person, $150,000 for bodily injury to or death of 2 or more persons in any one motor vehicle accident, or the corresponding policy limits for bodily injury or death, whichever is less. All 3-person arbitration cases proceeding in accordance with any uninsured motorist coverage conducted in this State in which the claimant is only seeking monetary damages up to the limits set forth in Section 7-203 of the Illinois Vehicle Code shall be subject to the following rules:

(A) If at least 60 days' written notice of the intention to offer the following documents in evidence is given to every other party, accompanied by a copy of the document, a party may offer in evidence, without foundation or other proof:

(1) bills, records, and reports of hospitals, doctors, dentists, registered nurses, licensed

practical nurses, physical therapists, and other healthcare providers;

(2) bills for drugs, medical appliances, and prostheses;

(3) property repair bills or estimates, when identified and itemized setting forth the charges for labor and material used or proposed for use in the repair of the property;

(4) a report of the rate of earnings and time lost from work or lost compensation prepared by an employer;

(5) the written opinion of an opinion witness, the deposition of a witness, and the statement of a witness that the witness would be allowed to express if testifying in person, if the opinion or statement is made by affidavit or by certification as provided in Section 1-109 of the Code of Civil Procedure;

(6) any other document not specifically covered by any of the foregoing provisions that is otherwise admissible under the rules of evidence.

Any party receiving a notice under this paragraph (A) may apply to the arbitrator or panel of arbitrators, as the case may be, for the issuance of a subpoena directed to the author or maker or custodian of the document that is the subject of the notice, requiring the person subpoenaed to produce copies of any additional documents as may be

related to the subject matter of the document that is the subject of the notice. Any such subpoena shall be issued in substantially similar form and served by notice as provided by Illinois Supreme Court Rule 204(a)(4). Any such subpoena shall be returnable not less than 5 days before the arbitration hearing.

(B) Notwithstanding the provisions of Supreme Court Rule 213(g), a party who proposes to use a written opinion of an expert or opinion witness or the testimony of an expert or opinion witness at the hearing may do so provided a written notice of that intention is given to every other party not less than 60 days prior to the date of hearing, accompanied by a statement containing the identity of the witness, his or her qualifications, the subject matter, the basis of the witness's conclusions, and his or her opinion.

(C) Any other party may subpoena the author or maker of a document admissible under this subsection, at that party's expense, and examine the author or maker as if under cross-examination. The provisions of Section 2-1101 of the Code of Civil Procedure shall be applicable to arbitration hearings, and it shall be the duty of a party requesting the subpoena to modify the form to show that the appearance is set before an arbitration panel and to give the time and place set for the hearing.

(D) The provisions of Section 2-1102 of the Code of

Civil Procedure shall be applicable to arbitration hearings under this subsection.

(2) No policy insuring against loss resulting from liability imposed by law for property damage arising out of the ownership, maintenance, or use of a motor vehicle shall be renewed, delivered, or issued for delivery in this State with respect to any private passenger or recreational motor vehicle that is designed for use on public highways and that is either required to be registered in this State or is principally garaged in this State ~~and is not covered by collision insurance under the provisions of such policy~~, unless coverage is made available in the amount of the actual cash value of the motor vehicle described in the policy or the corresponding policy limit for uninsured motor vehicle property damage coverage, ~~$15,000~~ whichever is less, subject to a maximum $250 deductible, for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles and hit-and-run motor vehicles because of property damage to the motor vehicle described in the policy.

There shall be no liability imposed under the uninsured motorist property damage coverage required by this subsection if the owner or operator of the at-fault uninsured motor vehicle or hit-and-run motor vehicle cannot be identified. This subsection shall not apply to any policy which does not provide primary motor vehicle liability insurance for

liabilities arising from the maintenance, operation, or use of a specifically insured motor vehicle.

Each insurance company providing motor vehicle property damage liability insurance shall advise applicants of the availability of uninsured motor vehicle property damage coverage, the premium therefor, and provide a brief description of the coverage. That information need be given only once and shall not be required in any subsequent renewal, reinstatement or reissuance, substitute, amended, replacement or supplementary policy. No written rejection shall be required, and the absence of a premium payment for uninsured motor vehicle property damage shall constitute conclusive proof that the applicant or policyholder has elected not to accept uninsured motorist property damage coverage.

An insurance company issuing uninsured motor vehicle property damage coverage may provide that:

(i) Property damage losses recoverable thereunder shall be limited to damages caused by the actual physical contact of an uninsured motor vehicle with the insured motor vehicle.

(ii) There shall be no coverage for loss of use of the insured motor vehicle and no coverage for loss or damage to personal property located in the insured motor vehicle.

(iii) Any claim submitted shall include the name and address of the owner of the at-fault uninsured motor vehicle, or a registration number and description of the

vehicle, or any other available information to establish that there is no applicable motor vehicle property damage liability insurance.

Any dispute with respect to the coverage and the amount of damages shall be submitted for arbitration to the American Arbitration Association and be subject to its rules for the conduct of arbitration hearings or for determination in the following manner: Upon the insured requesting arbitration, each party to the dispute shall select an arbitrator and the 2 arbitrators so named shall select a third arbitrator. If such arbitrators are not selected within 45 days from such request, either party may request that the arbitration be submitted to the American Arbitration Association. Any arbitration proceeding under this subsection seeking recovery for property damages shall be subject to the following rules:

(A) If at least 60 days' written notice of the intention to offer the following documents in evidence is given to every other party, accompanied by a copy of the document, a party may offer in evidence, without foundation or other proof:

(1) property repair bills or estimates, when identified and itemized setting forth the charges for labor and material used or proposed for use in the repair of the property;

(2) the written opinion of an opinion witness, the deposition of a witness, and the statement of a

witness that the witness would be allowed to express if testifying in person, if the opinion or statement is made by affidavit or by certification as provided in Section 1-109 of the Code of Civil Procedure;

(3) any other document not specifically covered by any of the foregoing provisions that is otherwise admissible under the rules of evidence.

Any party receiving a notice under this paragraph (A) may apply to the arbitrator or panel of arbitrators, as the case may be, for the issuance of a subpoena directed to the author or maker or custodian of the document that is the subject of the notice, requiring the person subpoenaed to produce copies of any additional documents as may be related to the subject matter of the document that is the subject of the notice. Any such subpoena shall be issued in substantially similar form and served by notice as provided by Illinois Supreme Court Rule 204(a)(4). Any such subpoena shall be returnable not less than 5 days before the arbitration hearing.

(B) Notwithstanding the provisions of Supreme Court Rule 213(g), a party who proposes to use a written opinion of an expert or opinion witness or the testimony of an expert or opinion witness at the hearing may do so provided a written notice of that intention is given to every other party not less than 60 days prior to the date of hearing, accompanied by a statement containing the

identity of the witness, his or her qualifications, the subject matter, the basis of the witness's conclusions, and his or her opinion.

(C) Any other party may subpoena the author or maker of a document admissible under this subsection, at that party's expense, and examine the author or maker as if under cross-examination. The provisions of Section 2-1101 of the Code of Civil Procedure shall be applicable to arbitration hearings, and it shall be the duty of a party requesting the subpoena to modify the form to show that the appearance is set before an arbitration panel and to give the time and place set for the hearing.

(D) The provisions of Section 2-1102 of the Code of Civil Procedure shall be applicable to arbitration hearings under this subsection.

(3) For the purpose of the coverage, the term "uninsured motor vehicle" includes, subject to the terms and conditions of the coverage, a motor vehicle where on, before or after the accident date the liability insurer thereof is unable to make payment with respect to the legal liability of its insured within the limits specified in the policy because of the entry by a court of competent jurisdiction of an order of rehabilitation or liquidation by reason of insolvency on or after the accident date. An insurer's extension of coverage, as provided in this subsection, shall be applicable to all accidents occurring after July 1, 1967 during a policy period

in which its insured's uninsured motor vehicle coverage is in effect. Nothing in this Section may be construed to prevent any insurer from extending coverage under terms and conditions more favorable to its insureds than is required by this Section.

(4) In the event of payment to any person under the coverage required by this Section and subject to the terms and conditions of the coverage, the insurer making the payment shall, to the extent thereof, be entitled to the proceeds of any settlement or judgment resulting from the exercise of any rights of recovery of the person against any person or organization legally responsible for the property damage, bodily injury or death for which the payment is made, including the proceeds recoverable from the assets of the insolvent insurer. With respect to payments made by reason of the coverage described in subsection (3), the insurer making such payment shall not be entitled to any right of recovery against the tortfeasor in excess of the proceeds recovered from the assets of the insolvent insurer of the tortfeasor.

(5) This amendatory Act of 1967 (Laws of Illinois 1967, page 875) shall not be construed to terminate or reduce any insurance coverage or any right of any party under this Code in effect before July 1, 1967. Public Act 86-1155 shall not be construed to terminate or reduce any insurance coverage or any right of any party under this Code in effect before its effective date.

(6) Failure of the motorist from whom the claimant is legally entitled to recover damages to file the appropriate forms with the Safety Responsibility Section of the Department of Transportation within 120 days of the accident date shall create a rebuttable presumption that the motorist was uninsured at the time of the injurious occurrence.

(7) An insurance carrier may upon good cause require the insured to commence a legal action against the owner or operator of an uninsured motor vehicle before good faith negotiation with the carrier. If the action is commenced at the request of the insurance carrier, the carrier shall pay to the insured, before the action is commenced, all court costs, jury fees and sheriff's fees arising from the action.

The changes made by Public Act 90-451 apply to all policies of insurance amended, delivered, issued, or renewed on and after January 1, 1998 (the effective date of Public Act 90-451).

(8) The changes made by Public Act 98-927 apply to all policies of insurance amended, delivered, issued, or renewed on and after January 1, 2015 (the effective date of Public Act 98-927).

(Source: P.A. 98-242, eff. 1-1-14; 98-927, eff. 1-1-15; 99-642, eff. 7-28-16.)

(215 ILCS 5/155.23) (from Ch. 73, par. 767.23)

Sec. 155.23. Fraud reporting.

(1) The Director is authorized to request an insurer ~~promulgate reasonable rules requiring insurers~~, as defined in Section 155.24, doing business in the State of Illinois to report factual information in their possession that is pertinent to suspected fraudulent insurance claims, fraudulent insurance applications, or premium fraud after ~~he has made~~ a determination that the information is necessary to detect fraud or arson. ~~Claim information may include:~~

(2) The Director may designate one or more data processing organizations or governmental agencies to assist in gathering such information and making compilations thereof and may in such case provide for a fee to be paid by the reporting insurers directly to the designated organization or agency to cover any of the costs associated with providing this service.

(3) Upon written request to an insurer by the data processing organization or governmental agency, an insurer or agent authorized by an insurer to act on its behalf shall release to the requesting designated data processing organization or governmental agency all relevant information deemed important to the data processing organization or governmental agency which the insurer may possess relating to fraud or arson. Relevant information may include, but is not limited to:

(a) Dates and description of accident or loss.

(b) Any insurance policy relevant to the accident or loss.

(c) Name of the insurance company claims adjustor and claims adjustor supervisor processing or reviewing any claim or claims made under any insurance policy relevant to the accident or loss.

(d) Name of claimant's or insured's attorney.

(e) Name of claimant's or insured's physician, or any person rendering or purporting to render medical treatment.

(f) Description of alleged injuries, damage or loss.

(g) History of previous claims made by the claimant or insured.

(h) Places of medical treatment.

(i) Policy premium payment record.

(j) Material relating to the investigation of the accident or loss, including statements of any person, proof of loss, and any other relevant evidence.

(k) any facts evidencing fraud or arson.

~~The Director shall establish reporting requirements for application and premium fraud information reporting by rule.~~

~~(2) The Director of Insurance may designate one or more data processing organizations or governmental agencies to assist him in gathering such information and making compilations thereof, and may by rule establish the form and procedure for gathering and compiling such information. The rules may name any organization or agency designated by the Director to provide this service, and may in such case provide~~

~~for a fee to be paid by the reporting insurers directly to the designated organization or agency to cover any of the costs associated with providing this service.~~

(4) After determination by the Director of substantial evidence of false or fraudulent claims, fraudulent applications, or premium fraud, the information shall be forwarded by the Director or the Director's designee to the proper law enforcement agency or prosecutor. Insurers shall have access to, and may use, the information compiled under the provisions of this Section. Insurers shall release information to, and shall cooperate with, any law enforcement agency requesting such information.

In the absence of malice, no insurer, or person who furnishes information on its behalf, is liable for damages in a civil action or subject to criminal prosecution for any oral or written statement made or any other action taken that is necessary to supply information required pursuant to this Section.

(Source: P.A. 92-233, eff. 1-1-02.)

(215 ILCS 5/229.4a)

Sec. 229.4a. Standard Non-forfeiture Law for Individual Deferred Annuities.

(1) Title. This Section shall be known as the Standard Nonforfeiture Law for Individual Deferred Annuities.

(2) Applicability. This Section shall not apply to any

reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this State through an agent or other representative of the company issuing the contract.

(3) Nonforfeiture Requirements.

(A) In the case of contracts issued on or after the operative date of this Section as defined in subsection (13), no contract of annuity, except as stated in subsection (2), shall be delivered or issued for delivery in this State unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the Director of Insurance are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract:

(i) That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the

contract of such value as is specified in subsections (5), (6), (7), (8) and (10);

(ii) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of a paid-up annuity benefit a cash surrender benefit of such amount as is specified in subsections (5), (6), (8) and (10). The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed 6 months after demand therefor with surrender of the contract after making written request and receiving written approval of the Director. The request shall address the necessity and equitability to all policyholders of the deferral;

(iii) A statement of the mortality table, if any, and interest rates used calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and

(iv) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which

the contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

(B) Notwithstanding the requirements of this Section, a deferred annuity contract may provide that if no considerations have been received under a contract for a period of 2 full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations paid would be less than $20 monthly, the company may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis on the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by this payment shall be relieved of any further obligation under the contract.

(4) Minimum values. The minimum values as specified in subsections (5), (6), (7), (8) and (10) of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this subsection.

(A)(i) The minimum nonforfeiture amount at any time at

or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in subdivision (4)(B) of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of paragraphs (a) through (d) below:

(a) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in subdivision (4)(B);

(b) An annual contract charge of $50, accumulated at rates of interest as indicated in subdivision (4)(B);

(c) Any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in subdivision (4)(B); and

(d) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(ii) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to 87.5% of the gross considerations, credited to the contract during that contract year.

(B) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of 3% per annum and the following, which shall be specified in the contract if the interest rate will be reset:

(i) The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest 1/20th of one percent, specified in the contract no longer than 15 months prior to the contract issue date or redetermination date under subdivision (4)(B)(iv);

(ii) Reduced by 125 basis points;

(iii) Where the resulting interest rate is not less than 0.15% ~~1%~~; and

(iv) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the 5-year Constant Maturity Treasury Rate to be used at each redetermination date.

(C) During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in subdivision (4)(B)(ii) above by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed market value of the benefit. The Director may require a demonstration that the present value of the additional reduction does not exceed the

market value of the benefit. Lacking such a demonstration that is acceptable to the Director, the Director may disallow or limit the additional reduction.

(D) The Director may adopt rules to implement the provisions of subdivision (4)(C) and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the Director determines adjustments are justified.

(5) Computation of Present Value. Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(6) Calculation of Cash Surrender Value. For contracts that provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior

withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than 1% higher than the interest rate specified in the contract for accumulating the net considerations to determine maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(7) Calculation of Paid-up Annuity Benefits. For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value, and increased by any additional amounts credited by the company to the contract. For contracts that do not provide any death benefits

prior to the commencement of any annuity payments, present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(8) Maturity Date. For the purpose of determining the benefits calculated under subsections (6) and (7), in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

(9) Disclosure of Limited Death Benefits. A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

(10) Inclusion of Lapse of Time Considerations. Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be

calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(11) Proration of Values; Additional Benefits. For a contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of subsections (5), (6), (7), (8) and (10), additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required under this Section. The inclusion of such benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and

death benefits.

(12) Rules. The Director may adopt rules to implement the provisions of this Section.

(13) Effective Date. After the effective date of this amendatory Act of the 93rd General Assembly, a company may elect to apply its provisions to annuity contracts on a contract form-by-contract form basis before July 1, 2006. In all other instances, this Section shall become operative with respect to annuity contracts issued by the company on or after July 1, 2006.

(14) (Blank).

(Source: P.A. 93-873, eff. 8-6-04; 94-1076, eff. 12-29-06.)

(215 ILCS 5/353a) (from Ch. 73, par. 965a)

Sec. 353a. Accident and health reserves.

The reserves for all accident and health policies issued after the operative date of this section shall be computed and maintained on a basis which shall place an actuarially sound value on the liabilities under such policies. To provide a basis for the determination of such actuarially sound value, the Director from time to time shall adopt rules requiring the use of appropriate tables of morbidity, mortality, interest rates and valuation methods for such reserves <u>for policies issued before January 1, 2017. For policies issued on or after January 1, 2017, Section 223 shall govern the basis for determining such actuarially sound value</u>. In no event shall

such reserves be less than the pro rata gross unearned premium reserve for such policies.

The company shall give the notice required in section 234 on all non-cancellable accident and health policies.

After this section becomes effective, any company may file with the Director written notice of its election to comply with the provisions of this section after a specified date before January 1, 1967. After the filing of such notice, then upon such specified date (which shall be the operative date of this section for such company), this section shall become operative with respect to the accident and health policies thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be January 1, 1967.

After this section becomes effective, any company may file with the Director written notice of its election to establish and maintain reserves upon its accident and health policies issued prior to the operative date of this section in accordance with the standards for reserves established by this section, and thereafter the reserve standards prescribed pursuant to this section shall be effective with respect to said accident and health policies issued prior to the operative date of this section.

(Source: Laws 1965, p. 740.)

(215 ILCS 5/355a) (from Ch. 73, par. 967a)

Sec. 355a. Standardization of terms and coverage.

(1) The purposes of this Section shall be (a) to provide reasonable standardization and simplification of terms and coverages of individual accident and health insurance policies to facilitate public understanding and comparisons; (b) to eliminate provisions contained in individual accident and health insurance policies which may be misleading or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims; and (c) to provide for reasonable disclosure in the sale of accident and health coverages.

(2) Definitions applicable to this Section are as follows:

(a) "Policy" means all or any part of the forms constituting the contract between the insurer and the insured, including the policy, certificate, subscriber contract, riders, endorsements, and the application if attached, which are subject to filing with and approval by the Director.

(b) "Service corporations" means voluntary health and dental corporations organized and operating respectively under the Voluntary Health Services Plans Act and the Dental Service Plan Act.

(c) "Accident and health insurance" means insurance written under Article XX of this Code, other than credit accident and health insurance, and coverages provided in subscriber contracts issued by service corporations. For

purposes of this Section such service corporations shall be deemed to be insurers engaged in the business of insurance.

(3) The Director shall issue such rules as he shall deem necessary or desirable to establish specific standards, including standards of full and fair disclosure that set forth the form and content and required disclosure for sale, of individual policies of accident and health insurance, which rules and regulations shall be in addition to and in accordance with the applicable laws of this State, and which may cover but shall not be limited to: (a) terms of renewability; (b) initial and subsequent conditions of eligibility; (c) non-duplication of coverage provisions; (d) coverage of dependents; (e) pre-existing conditions; (f) termination of insurance; (g) probationary periods; (h) limitation, exceptions, and reductions; (i) elimination periods; (j) requirements regarding replacements; (k) recurrent conditions; and (l) the definition of terms, including, but not limited to, the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable, and non-cancellable.

The Director may issue rules that specify prohibited policy provisions not otherwise specifically authorized by statute which in the opinion of the Director are unjust, unfair or unfairly discriminatory to the policyholder, any

person insured under the policy, or beneficiary.

(4) The Director shall issue such rules as he shall deem necessary or desirable to establish minimum standards for benefits under each category of coverage in individual accident and health policies, other than conversion policies issued pursuant to a contractual conversion privilege under a group policy, including but not limited to the following categories: (a) basic hospital expense coverage; (b) basic medical-surgical expense coverage; (c) hospital confinement indemnity coverage; (d) major medical expense coverage; (e) disability income protection coverage; (f) accident only coverage; and (g) specified disease or specified accident coverage.

Nothing in this subsection (4) shall preclude the issuance of any policy which combines two or more of the categories of coverage enumerated in subparagraphs (a) through (f) of this subsection.

No policy shall be delivered or issued for delivery in this State which does not meet the prescribed minimum standards for the categories of coverage listed in this subsection unless the Director finds that such policy is necessary to meet specific needs of individuals or groups and such individuals or groups will be adequately informed that such policy does not meet the prescribed minimum standards, and such policy meets the requirement that the benefits provided therein are reasonable in relation to the premium

charged. The standards and criteria to be used by the Director in approving such policies shall be included in the rules required under this Section with as much specificity as practicable.

The Director shall prescribe by rule the method of identification of policies based upon coverages provided.

(5) (a) In order to provide for full and fair disclosure in the sale of individual accident and health insurance policies, no such policy shall be delivered or issued for delivery in this State unless the outline of coverage described in paragraph (b) of this subsection either accompanies the policy, or is delivered to the applicant at the time the application is made, and an acknowledgment signed by the insured, of receipt of delivery of such outline, is provided to the insurer. In the event the policy is issued on a basis other than that applied for, the outline of coverage properly describing the policy must accompany the policy when it is delivered and such outline shall clearly state that the policy differs, and to what extent, from that for which application was originally made. All policies, except single premium nonrenewal policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance, that the policyholder shall have the right to return the policy within 10 days of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.

(b) The Director shall issue such rules as he shall deem necessary or desirable to prescribe the format and content of the outline of coverage required by paragraph (a) of this subsection. "Format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. "Content" shall include without limitation thereto, statements relating to the particular policy as to the applicable category of coverage prescribed under subsection (4); principal benefits; exceptions, reductions and limitations; and renewal provisions, including any reservation by the insurer of a right to change premiums. Such outline of coverage shall clearly state that it constitutes a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c) (Blank). ~~Without limiting the generality of paragraph (b) of this subsection (5), no qualified health plans shall be offered for sale directly to consumers through the health insurance marketplace operating in the State in accordance with Sections 1311 and 1321 of the federal Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued thereunder (collectively, "the Federal Act"), unless the following information is made available to the consumer at the~~

time he or she is comparing policies and their premiums:

(i) With respect to prescription drug benefits, the most recently published formulary where a consumer can view in one location covered prescription drugs; information on tiering and the cost sharing structure for each tier; and information about how a consumer can obtain specific copayment amounts or coinsurance percentages for a specific qualified health plan before enrolling in that plan. This information shall clearly identify the qualified health plan to which it applies.

(ii) The most recently published provider directory where a consumer can view the provider network that applies to each qualified health plan and information about each provider, including location, contact information, specialty, medical group, if any, any institutional affiliation, and whether the provider is accepting new patients at each of the specific locations listing the provider. Dental providers shall notify qualified health plans electronically or in writing of any changes to their information as listed in the provider directory. Qualified health plans shall update their directories in a manner consistent with the information provided by the provider or dental management service organization within 10 business days after being notified of the change by the provider. Nothing in this paragraph (ii) shall void any contractual relationship between the

~~provider and the plan. The information shall clearly identify the qualified health plan to which it applies.~~

(d) (Blank). ~~Each company that offers qualified health plans for sale directly to consumers through the health insurance marketplace operating in the State shall make the information in paragraph (c) of this subsection (5), for each qualified health plan that it offers, available and accessible to the general public on the company's Internet website and through other means for individuals without access to the Internet.~~

(e) (Blank). ~~The Department shall ensure that State-operated Internet websites, in addition to the Internet website for the health insurance marketplace established in this State in accordance with the Federal Act, prominently provide links to Internet-based materials and tools to help consumers be informed purchasers of health insurance.~~

(f) (Blank). ~~Nothing in this Section shall be interpreted or implemented in a manner not consistent with the Federal Act. This Section shall apply to all qualified health plans offered for sale directly to consumers through the health insurance marketplace operating in this State for any coverage year beginning on or after January 1, 2015.~~

(6) Prior to the issuance of rules pursuant to this Section, the Director shall afford the public, including the companies affected thereby, reasonable opportunity for comment. Such rulemaking is subject to the provisions of the

Illinois Administrative Procedure Act.

(7) When a rule has been adopted, pursuant to this Section, all policies of insurance or subscriber contracts which are not in compliance with such rule shall, when so provided in such rule, be deemed to be disapproved as of a date specified in such rule not less than 120 days following its effective date, without any further or additional notice other than the adoption of the rule.

(8) When a rule adopted pursuant to this Section so provides, a policy of insurance or subscriber contract which does not comply with the rule shall, not less than 120 days from the effective date of such rule, be construed, and the insurer or service corporation shall be liable, as if the policy or contract did comply with the rule.

(9) Violation of any rule adopted pursuant to this Section shall be a violation of the insurance law for purposes of Sections 370 and 446 of this Code.

(Source: P.A. 99-329, eff. 1-1-16; 100-201, eff. 8-18-17.)

(215 ILCS 5/355c new)

Sec. 355c. Availability of information on qualified health plans.

(a) Without limiting the generality of paragraph (b) of subsection (5) of Section 355a, no qualified health plans shall be offered for sale directly to consumers through the health insurance marketplace operating in this State in

accordance with Sections 1311 and 1321 of the federal Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued thereunder (collectively, "the Federal Act"), unless the following information is made available to the consumer at the time he or she is comparing policies and their premiums:

(1) With respect to prescription drug benefits, the most recently published formulary where a consumer can view in one location covered prescription drugs; information on tiering and the cost-sharing structure for each tier; and information about how a consumer can obtain specific copayment amounts or coinsurance percentages for a specific qualified health plan before enrolling in that plan. This information shall clearly identify the qualified health plan to which it applies.

(2) The most recently published provider directory where a consumer can view the provider network that applies to each qualified health plan and information about each provider, including location, contact information, specialty, medical group, if any, any institutional affiliation, and whether the provider is accepting new patients at each of the specific locations listing the provider. Dental providers shall notify qualified health plans electronically or in writing of any

changes to their information as listed in the provider directory. Qualified health plans shall update their directories in a manner consistent with the information provided by the provider or dental management service organization within 10 business days after being notified of the change by the provider. Nothing in this paragraph (2) shall void any contractual relationship between the provider and the plan. The information shall clearly identify the qualified health plan to which it applies.

(b) Each company that offers qualified health plans for sale directly to consumers through the health insurance marketplace operating in this State shall make the information in subsection (a), for each qualified health plan that it offers, available and accessible to the general public on the company's website and through other means for individuals without access to the Internet.

(c) The Department shall ensure that State-operated websites, in addition to the website for the health insurance marketplace established in this State in accordance with the Federal Act, prominently provide links to Internet-based materials and tools to help consumers be informed purchasers of health insurance.

(d) Nothing in this Section shall be interpreted or implemented in a manner not consistent with the Federal Act. This Section shall apply to all qualified health plans offered for sale directly to consumers through the health insurance

marketplace operating in this State for any coverage year beginning on or after January 1, 2015.

(215 ILCS 5/412) (from Ch. 73, par. 1024)

Sec. 412. Refunds; penalties; collection.

(1)(a) Whenever it appears to the satisfaction of the Director that because of some mistake of fact, error in calculation, or erroneous interpretation of a statute of this or any other state, any authorized company, surplus line producer, or industrial insured has paid to him, pursuant to any provision of law, taxes, fees, or other charges in excess of the amount legally chargeable against it, during the 6 year period immediately preceding the discovery of such overpayment, he shall have power to refund to such company, surplus line producer, or industrial insured the amount of the excess or excesses by applying the amount or amounts thereof toward the payment of taxes, fees, or other charges already due, or which may thereafter become due from that company until such excess or excesses have been fully refunded, or upon a written request from the authorized company, surplus line producer, or industrial insured, the Director shall provide a cash refund within 120 days after receipt of the written request if all necessary information has been filed with the Department in order for it to perform an audit of the tax report for the transaction or period or annual return for the year in which the overpayment occurred or within 120 days

after the date the Department receives all the necessary information to perform such audit. The Director shall not provide a cash refund if there are insufficient funds in the Insurance Premium Tax Refund Fund to provide a cash refund, if the amount of the overpayment is less than $100, or if the amount of the overpayment can be fully offset against the taxpayer's estimated liability for the year following the year of the cash refund request. Any cash refund shall be paid from the Insurance Premium Tax Refund Fund, a special fund hereby created in the State treasury.

(b) As determined by the Director pursuant to paragraph (a) of this subsection ~~Beginning January 1, 2000 and thereafter~~, the Department shall deposit an amount of cash refunds approved by the Director for payment as a result of overpayment of tax liability ~~a percentage of the amounts~~ collected under Sections 121-2.08, 409, 444, ~~and~~ 444.1, and 445 of this Code into the Insurance Premium Tax Refund Fund. ~~The percentage deposited into the Insurance Premium Tax Refund Fund shall be the annual percentage. The annual percentage shall be calculated as a fraction, the numerator of which shall be the amount of cash refunds approved by the Director for payment and paid during the preceding calendar year as a result of overpayment of tax liability under Sections 121-2.08, 409, 444, 444.1, and 445 of this Code and the denominator of which shall be the amounts collected pursuant to Sections 121-2.08, 409, 444, 444.1, and 445 of this Code~~

~~during the preceding calendar year. However, if there were no cash refunds paid in a preceding calendar year, the Department shall deposit 5% of the amount collected in that preceding calendar year pursuant to Sections 121-2.08, 409, 444, 444.1, and 445 of this Code into the Insurance Premium Tax Refund Fund instead of an amount calculated by using the annual percentage.~~

(c) Beginning July 1, 1999, moneys in the Insurance Premium Tax Refund Fund shall be expended exclusively for the purpose of paying cash refunds resulting from overpayment of tax liability under Sections 121-2.08, 409, 444, 444.1, and 445 of this Code as determined by the Director pursuant to subsection 1(a) of this Section. Cash refunds made in accordance with this Section may be made from the Insurance Premium Tax Refund Fund only to the extent that amounts have been deposited and retained in the Insurance Premium Tax Refund Fund.

(d) This Section shall constitute an irrevocable and continuing appropriation from the Insurance Premium Tax Refund Fund for the purpose of paying cash refunds pursuant to the provisions of this Section.

(2)(a) When any insurance company fails to file any tax return required under Sections 408.1, 409, 444, and 444.1 of this Code or Section 12 of the Fire Investigation Act on the date prescribed, including any extensions, there shall be added as a penalty $400 or 10% of the amount of such tax,

whichever is greater, for each month or part of a month of failure to file, the entire penalty not to exceed $2,000 or 50% of the tax due, whichever is greater.

(b) When any industrial insured or surplus line producer fails to file any tax return or report required under Sections 121-2.08 and 445 of this Code or Section 12 of the Fire Investigation Act on the date prescribed, including any extensions, there shall be added:

(i) as a late fee, if the return or report is received at least one day but not more than 7 days after the prescribed due date, $400 or 10% of the tax due, whichever is greater, the entire fee not to exceed $1,000;

(ii) as a late fee, if the return or report is received at least 8 days but not more than 14 days after the prescribed due date, $400 or 10% of the tax due, whichever is greater, the entire fee not to exceed $1,500;

(iii) as a late fee, if the return or report is received at least 15 days but not more than 21 days after the prescribed due date, $400 or 10% of the tax due, whichever is greater, the entire fee not to exceed $2,000; or

(iv) as a penalty, if the return or report is received more than 21 days after the prescribed due date, $400 or 10% of the tax due, whichever is greater, for each month or part of a month of failure to file, the entire penalty not to exceed $2,000 or 50% of the tax due, whichever is

greater.

A tax return or report shall be deemed received as of the date mailed as evidenced by a postmark, proof of mailing on a recognized United States Postal Service form or a form acceptable to the United States Postal Service or other commercial mail delivery service, or other evidence acceptable to the Director.

(3)(a) When any insurance company fails to pay the full amount due under the provisions of this Section, Sections 408.1, 409, 444, or 444.1 of this Code, or Section 12 of the Fire Investigation Act, there shall be added to the amount due as a penalty an amount equal to 10% of the deficiency.

(a-5) When any industrial insured or surplus line producer fails to pay the full amount due under the provisions of this Section, Sections 121-2.08 or 445 of this Code, or Section 12 of the Fire Investigation Act on the date prescribed, there shall be added:

(i) as a late fee, if the payment is received at least one day but not more than 7 days after the prescribed due date, 10% of the tax due, the entire fee not to exceed $1,000;

(ii) as a late fee, if the payment is received at least 8 days but not more than 14 days after the prescribed due date, 10% of the tax due, the entire fee not to exceed $1,500;

(iii) as a late fee, if the payment is received at

least 15 days but not more than 21 days after the prescribed due date, 10% of the tax due, the entire fee not to exceed $2,000; or

(iv) as a penalty, if the return or report is received more than 21 days after the prescribed due date, 10% of the tax due.

A tax payment shall be deemed received as of the date mailed as evidenced by a postmark, proof of mailing on a recognized United States Postal Service form or a form acceptable to the United States Postal Service or other commercial mail delivery service, or other evidence acceptable to the Director.

(b) If such failure to pay is determined by the Director to be wilful, after a hearing under Sections 402 and 403, there shall be added to the tax as a penalty an amount equal to the greater of 50% of the deficiency or 10% of the amount due and unpaid for each month or part of a month that the deficiency remains unpaid commencing with the date that the amount becomes due. Such amount shall be in lieu of any determined under paragraph (a) or (a-5).

(4) Any insurance company, industrial insured, or surplus line producer that fails to pay the full amount due under this Section or Sections 121-2.08, 408.1, 409, 444, 444.1, or 445 of this Code, or Section 12 of the Fire Investigation Act is liable, in addition to the tax and any late fees and penalties, for interest on such deficiency at the rate of 12% per annum,

or at such higher adjusted rates as are or may be established under subsection (b) of Section 6621 of the Internal Revenue Code, from the date that payment of any such tax was due, determined without regard to any extensions, to the date of payment of such amount.

(5) The Director, through the Attorney General, may institute an action in the name of the People of the State of Illinois, in any court of competent jurisdiction, for the recovery of the amount of such taxes, fees, and penalties due, and prosecute the same to final judgment, and take such steps as are necessary to collect the same.

(6) In the event that the certificate of authority of a foreign or alien company is revoked for any cause or the company withdraws from this State prior to the renewal date of the certificate of authority as provided in Section 114, the company may recover the amount of any such tax paid in advance. Except as provided in this subsection, no revocation or withdrawal excuses payment of or constitutes grounds for the recovery of any taxes or penalties imposed by this Code.

(7) When an insurance company or domestic affiliated group fails to pay the full amount of any fee of $200 or more due under Section 408 of this Code, there shall be added to the amount due as a penalty the greater of $100 or an amount equal to 10% of the deficiency for each month or part of a month that the deficiency remains unpaid.

(8) The Department shall have a lien for the taxes, fees,

charges, fines, penalties, interest, other charges, or any portion thereof, imposed or assessed pursuant to this Code, upon all the real and personal property of any company or person to whom the assessment or final order has been issued or whenever a tax return is filed without payment of the tax or penalty shown therein to be due, including all such property of the company or person acquired after receipt of the assessment, issuance of the order, or filing of the return. The company or person is liable for the filing fee incurred by the Department for filing the lien and the filing fee incurred by the Department to file the release of that lien. The filing fees shall be paid to the Department in addition to payment of the tax, fee, charge, fine, penalty, interest, other charges, or any portion thereof, included in the amount of the lien. However, where the lien arises because of the issuance of a final order of the Director or tax assessment by the Department, the lien shall not attach and the notice referred to in this Section shall not be filed until all administrative proceedings or proceedings in court for review of the final order or assessment have terminated or the time for the taking thereof has expired without such proceedings being instituted.

Upon the granting of Department review after a lien has attached, the lien shall remain in full force except to the extent to which the final assessment may be reduced by a revised final assessment following the rehearing or review. The lien created by the issuance of a final assessment shall

terminate, unless a notice of lien is filed, within 3 years after the date all proceedings in court for the review of the final assessment have terminated or the time for the taking thereof has expired without such proceedings being instituted, or (in the case of a revised final assessment issued pursuant to a rehearing or review by the Department) within 3 years after the date all proceedings in court for the review of such revised final assessment have terminated or the time for the taking thereof has expired without such proceedings being instituted. Where the lien results from the filing of a tax return without payment of the tax or penalty shown therein to be due, the lien shall terminate, unless a notice of lien is filed, within 3 years after the date when the return is filed with the Department.

The time limitation period on the Department's right to file a notice of lien shall not run during any period of time in which the order of any court has the effect of enjoining or restraining the Department from filing such notice of lien. If the Department finds that a company or person is about to depart from the State, to conceal himself or his property, or to do any other act tending to prejudice or to render wholly or partly ineffectual proceedings to collect the amount due and owing to the Department unless such proceedings are brought without delay, or if the Department finds that the collection of the amount due from any company or person will be jeopardized by delay, the Department shall give the company or

person notice of such findings and shall make demand for immediate return and payment of the amount, whereupon the amount shall become immediately due and payable. If the company or person, within 5 days after the notice (or within such extension of time as the Department may grant), does not comply with the notice or show to the Department that the findings in the notice are erroneous, the Department may file a notice of jeopardy assessment lien in the office of the recorder of the county in which any property of the company or person may be located and shall notify the company or person of the filing. The jeopardy assessment lien shall have the same scope and effect as the statutory lien provided for in this Section. If the company or person believes that the company or person does not owe some or all of the tax for which the jeopardy assessment lien against the company or person has been filed, or that no jeopardy to the revenue in fact exists, the company or person may protest within 20 days after being notified by the Department of the filing of the jeopardy assessment lien and request a hearing, whereupon the Department shall hold a hearing in conformity with the provisions of this Code and, pursuant thereto, shall notify the company or person of its findings as to whether or not the jeopardy assessment lien will be released. If not, and if the company or person is aggrieved by this decision, the company or person may file an action for judicial review of the final determination of the Department in accordance with the

Administrative Review Law. If, pursuant to such hearing (or after an independent determination of the facts by the Department without a hearing), the Department determines that some or all of the amount due covered by the jeopardy assessment lien is not owed by the company or person, or that no jeopardy to the revenue exists, or if on judicial review the final judgment of the court is that the company or person does not owe some or all of the amount due covered by the jeopardy assessment lien against them, or that no jeopardy to the revenue exists, the Department shall release its jeopardy assessment lien to the extent of such finding of nonliability for the amount, or to the extent of such finding of no jeopardy to the revenue. The Department shall also release its jeopardy assessment lien against the company or person whenever the amount due and owing covered by the lien, plus any interest which may be due, are paid and the company or person has paid the Department in cash or by guaranteed remittance an amount representing the filing fee for the lien and the filing fee for the release of that lien. The Department shall file that release of lien with the recorder of the county where that lien was filed.

Nothing in this Section shall be construed to give the Department a preference over the rights of any bona fide purchaser, holder of a security interest, mechanics lienholder, mortgagee, or judgment lien creditor arising prior to the filing of a regular notice of lien or a notice of

jeopardy assessment lien in the office of the recorder in the county in which the property subject to the lien is located. For purposes of this Section, "bona fide" shall not include any mortgage of real or personal property or any other credit transaction that results in the mortgagee or the holder of the security acting as trustee for unsecured creditors of the company or person mentioned in the notice of lien who executed such chattel or real property mortgage or the document evidencing such credit transaction. The lien shall be inferior to the lien of general taxes, special assessments, and special taxes levied by any political subdivision of this State. In case title to land to be affected by the notice of lien or notice of jeopardy assessment lien is registered under the provisions of the Registered Titles (Torrens) Act, such notice shall be filed in the office of the Registrar of Titles of the county within which the property subject to the lien is situated and shall be entered upon the register of titles as a memorial or charge upon each folium of the register of titles affected by such notice, and the Department shall not have a preference over the rights of any bona fide purchaser, mortgagee, judgment creditor, or other lienholder arising prior to the registration of such notice. The regular lien or jeopardy assessment lien shall not be effective against any purchaser with respect to any item in a retailer's stock in trade purchased from the retailer in the usual course of the retailer's business.

(Source: P.A. 98-158, eff. 8-2-13; 98-978, eff. 1-1-15.)

(215 ILCS 5/356z.27 rep.)

Section 10. The Illinois Insurance Code is amended by repealing Section 356z.27.

Section 15. The Illinois Health Insurance Portability and Accountability Act is amended by changing Section 20 as follows:

(215 ILCS 97/20)

Sec. 20. Increased portability through prohibition of ~~limitation on~~ preexisting condition exclusions.

(A) No health insurance coverage issued, amended, delivered, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly may impose any preexisting condition exclusion with respect to the plan or coverage. This provision does not apply to the provision of excepted benefits as described in paragraph (2) of subsection (C). ~~Limitation of preexisting condition exclusion period; crediting for periods of previous coverage. Subject to subsection (D), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:~~

~~(1) the exclusion relates to a condition (whether~~

~~physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;~~

~~(2) the exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and~~

~~(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (C)(1)) applicable to the participant or beneficiary as of the enrollment date.~~

(B) (Blank). ~~Preexisting condition exclusion. A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.~~

~~Genetic information shall not be treated as a condition described in subsection (A)(1) in the absence of a diagnosis of the condition related to such information.~~

(C) Rules relating to crediting previous coverage.

(1) Creditable coverage defined. For purposes of this Act, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(a) A group health plan.

(b) Health insurance coverage.

(c) Part A or part B of title XVIII of the Social Security Act.

(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928.

(e) Chapter 55 of title 10, United States Code.

(f) A medical care program of the Indian Health Service or of a tribal organization.

(g) A State health benefits risk pool.

(h) A health plan offered under chapter 89 of title 5, United States Code.

(i) A public health plan (as defined in regulations).

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(k) Title XXI of the federal Social Security Act, State Children's Health Insurance Program.

Such term does not include coverage consisting solely of coverage of excepted benefits.

(2) Excepted benefits. For purposes of this Act, the term "excepted benefits" means benefits under one or more of the following:

(a) Benefits not subject to requirements:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Coverage issued as a supplement to

liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) Benefits not subject to requirements if offered separately:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Such other similar, limited benefits as are specified in rules.

(c) Benefits not subject to requirements if offered, as independent, noncoordinated benefits:

(i) Coverage only for a specified disease or illness.

(ii) Hospital indemnity or other fixed

indemnity insurance.

(d) Benefits not subject to requirements if offered as separate insurance policy. Medicare supplemental health insurance (as defined under Section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(3) Not counting periods before significant breaks in coverage.

(a) In general. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(b) Waiting period not treated as a break in coverage. For purposes of subparagraph (a) and subsection (D)(3), any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (G)(2)) shall not be taken into account in determining the continuous period under subparagraph (a).

(4) (Blank). ~~Method of crediting coverage.~~

~~(a) Standard method. Except as otherwise provided under subparagraph (b), for purposes of applying subsection (A)(3), a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.~~

~~(b) Election of alternative method. A group health plan, or a health insurance issuer offering group health insurance, may elect to apply subsection (A)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (a). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.~~

~~(c) Plan notice. In the case of an election with respect to a group health plan under subparagraph (b) (whether or not health insurance coverage is provided in connection with such plan), the plan shall:~~

~~(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan,~~

~~that the plan has made such election; and~~

~~(ii) include in such statements a description of the effect of this election.~~

~~(d) Issuer notice. In the case of an election under subparagraph (b) with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer:~~

~~(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election; and~~

~~(ii) shall include in such statements a description of the effect of such election.~~

(5) Establishment of period. Periods of creditable coverage with respect to an individual shall be established through presentation or certifications described in subsection (E) or in such other manner as may be specified in regulations.

(D) (Blank). ~~Exceptions:~~

~~(1) Exclusion not applicable to certain newborns. Subject to paragraph (3), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30 day period beginning with the date of birth,~~

~~is covered under creditable coverage.~~

~~(2) Exclusion not applicable to certain adopted children. Subject to paragraph (3), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30 day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage.~~

~~The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.~~

~~(3) Loss if break in coverage. Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63 day period during all of which the individual was not covered under any creditable coverage.~~

(E) Certifications and disclosure of coverage.

(1) Requirement for Certification of Period of Creditable Coverage.

(a) A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (b):

(i) at the time an individual ceases to be covered under the plan or otherwise becomes

covered under a COBRA continuation provision;

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision; and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(b) The certification described in this subparagraph is a written certification of:

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision; and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(c) To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the

health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) (Blank). ~~Disclosure of information on previous benefits. In the case of an election described in subsection (C)(4)(b) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1):~~

~~(a) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage; and~~

~~(b) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.~~

(3) Rules. The Department shall establish rules to prevent an entity's failure to provide information under paragraph (1) ~~or (2)~~ with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(4) Treatment of certain plans as group health plan

for notice provision. A program under which creditable coverage described in subparagraph (c), (d), (e), or (f) of Section 20(C)(1) is provided shall be treated as a group health plan for purposes of this Section.

(F) Special enrollment periods.

(1) Individuals losing other coverage. A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(b) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(c) The employee's or dependent's coverage described in subparagraph (a):

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

(d) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (c)(i) or termination of coverage or employer contributions described in subparagraph (c)(ii).

(2) For dependent beneficiaries.

(a) In general. If:

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to

becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

then the group health plan shall provide for a dependent special enrollment period described in subparagraph (b) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(b) Dependent special enrollment period. A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of:

(i) the date dependent coverage is made available; or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (a)(iii).

(c) No waiting period. If an individual seeks to

enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(G) Use of affiliation period by HMOs as alternative to preexisting condition exclusion.

(1) In general. A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any pre-existing condition exclusion ~~allowed under subsection (A)~~ with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if:

(a) such period is applied uniformly without regard to any health status-related factors; and

(b) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period.

(a) Defined. For purposes of this Act, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(b) Beginning. Such period shall begin on the enrollment date.

(c) Runs concurrently with waiting periods. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods. A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the Department.

(Source: P.A. 90-30, eff. 7-1-97; 90-736, eff. 8-12-98.)

Section 20. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2, 355.3, 355b, 355c, 356g.5-1, 356m, 356q, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.35, 356z.36, 356z.40, 356z.41, 356z.43, 356z.46, 356z.47, 356z.48, 356z.50, 356z.51, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents

of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and

the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service

agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable

or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19;

101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; revised 10-27-21.)

Section 25. The Limited Health Service Organization Act is amended by changing Section 4003 as follows:

(215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

Sec. 4003. Illinois Insurance Code provisions. Limited health service organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 355.2, 355.3, 355b, 356q, 356v, 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 364.3, ~~356z.43,~~ 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code. For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited health service organizations in the following categories are deemed to be domestic companies:

(1) a corporation under the laws of this State; or

(2) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a domestic company under Article VIII 1/2 of the Illinois Insurance Code.

(Source: P.A. 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; revised 10-27-21.)

Section 30. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b, 356g, 356g.5, 356g.5-1, 356q, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.40, 356z.41, 356z.46, 356z.47, 356z.51, ~~356z.43,~~ 364.01, 364.3,

367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; revised 10-27-21.)

Section 35. The Workers' Compensation Act is amended by changing Section 19 as follows:

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

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

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

1. Whenever any claimant misconceives his remedy and files an application for adjustment of claim under this

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

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

shall be deemed to be a notice under the provisions of this Act if given within the time required herein.

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

The hearings before the Arbitrator shall be held in the vicinity where the injury occurred after 10 days' notice of the time and place of such hearing shall have been given to each of the parties or their attorneys of record.

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

The decision of the Arbitrator shall be filed with the Commission which Commission shall immediately send to each party or his attorney a copy of such decision, together with a notification of the time when it was filed. As of the effective date of this amendatory Act of the 94th General Assembly, all decisions of the Arbitrator shall set forth in writing

findings of fact and conclusions of law, separately stated, if requested by either party. Unless a petition for review is filed by either party within 30 days after the receipt by such party of the copy of the decision and notification of time when filed, and unless such party petitioning for a review shall within 35 days after the receipt by him of the copy of the decision, file with the Commission either an agreed statement of the facts appearing upon the hearing before the Arbitrator, or if such party shall so elect a correct transcript of evidence of the proceedings at such hearings, then the decision shall become the decision of the Commission and in the absence of fraud shall be conclusive. The Petition for Review shall contain a statement of the petitioning party's specific exceptions to the decision of the arbitrator. The jurisdiction of the Commission to review the decision of the arbitrator shall not be limited to the exceptions stated in the Petition for Review. The Commission, or any member thereof, may grant further time not exceeding 30 days, in which to file such agreed statement or transcript of evidence. Such agreed statement of facts or correct transcript of evidence, as the case may be, shall be authenticated by the signatures of the parties or their attorneys, and in the event they do not agree as to the correctness of the transcript of evidence it shall be authenticated by the signature of the Arbitrator designated by the Commission.

Whether the employee is working or not, if the employee is

not receiving or has not received medical, surgical, or hospital services or other services or compensation as provided in paragraph (a) of Section 8, or compensation as provided in paragraph (b) of Section 8, the employee may at any time petition for an expedited hearing by an Arbitrator on the issue of whether or not he or she is entitled to receive payment of the services or compensation. Provided the employer continues to pay compensation pursuant to paragraph (b) of Section 8, the employer may at any time petition for an expedited hearing on the issue of whether or not the employee is entitled to receive medical, surgical, or hospital services or other services or compensation as provided in paragraph (a) of Section 8, or compensation as provided in paragraph (b) of Section 8. When an employer has petitioned for an expedited hearing, the employer shall continue to pay compensation as provided in paragraph (b) of Section 8 unless the arbitrator renders a decision that the employee is not entitled to the benefits that are the subject of the expedited hearing or unless the employee's treating physician has released the employee to return to work at his or her regular job with the employer or the employee actually returns to work at any other job. If the arbitrator renders a decision that the employee is not entitled to the benefits that are the subject of the expedited hearing, a petition for review filed by the employee shall receive the same priority as if the employee had filed a petition for an expedited hearing by an Arbitrator. Neither

party shall be entitled to an expedited hearing when the employee has returned to work and the sole issue in dispute amounts to less than 12 weeks of unpaid compensation pursuant to paragraph (b) of Section 8.

Expedited hearings shall have priority over all other petitions and shall be heard by the Arbitrator and Commission with all convenient speed. Any party requesting an expedited hearing shall give notice of a request for an expedited hearing under this paragraph. A copy of the Application for Adjustment of Claim shall be attached to the notice. The Commission shall adopt rules and procedures under which the final decision of the Commission under this paragraph is filed not later than 180 days from the date that the Petition for Review is filed with the Commission.

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

determined to be liable for coverage for the injury in issue shall reimburse any insurance carrier, private self-insured, or group workers' compensation pool that has paid benefits to or on behalf of petitioner for the injury.

(b-1) If the employee is not receiving medical, surgical or hospital services as provided in paragraph (a) of Section 8 or compensation as provided in paragraph (b) of Section 8, the employee, in accordance with Commission Rules, may file a petition for an emergency hearing by an Arbitrator on the issue of whether or not he is entitled to receive payment of such compensation or services as provided therein. Such petition shall have priority over all other petitions and shall be heard by the Arbitrator and Commission with all convenient speed.

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

(i) the date and approximate time of accident;

(ii) the approximate location of the accident;

(iii) a description of the accident;

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

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

(vi) the name and title of the person, if known,

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

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

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

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

(x) a copy of a signed report by a medical practitioner, relating to the employee's current inability to return to work because of the injuries incurred as a result of the accident or such other documents or affidavits which show that the employee is entitled to receive compensation pursuant to paragraph (b) of Section

8 of this Act or medical, surgical or hospital services pursuant to paragraph (a) of Section 8 of this Act. Such reports, documents or affidavits shall state, if possible, the history of the accident given by the employee, and describe the injury and medical diagnosis, the medical services for such injury which the employee has received and is receiving, the physical activities which the employee cannot currently perform as a result of any impairment or disability due to such injury, and the prognosis for recovery;

(xi) complete copies of any reports, records, documents and affidavits in the possession of the employee on which the employee will rely to support his allegations, provided that the employer shall pay the reasonable cost of reproduction thereof;

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

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

Fifteen days after receipt by the employer of the petition with the required information the employee may file said petition and required information and shall serve notice of the filing upon the employer. The employer may file a motion addressed to the sufficiency of the petition. If an objection

has been filed to the sufficiency of the petition, the arbitrator shall rule on the objection within 2 working days. If such an objection is filed, the time for filing the final decision of the Commission as provided in this paragraph shall be tolled until the arbitrator has determined that the petition is sufficient.

The employer shall, within 15 days after receipt of the notice that such petition is filed, file with the Commission and serve on the employee or his representative a written response to each claim set forth in the petition, including the legal and factual basis for each disputed allegation and the following information: (i) complete copies of any reports, records, documents and affidavits in the possession of the employer on which the employer intends to rely in support of his response, (ii) a list of any reports, records, documents and affidavits which the employer has demanded by subpoena and on which the employer intends to rely in support of his response, (iii) the name and address of each witness on whom the employer will rely to support his response, and (iv) the names and addresses of any medical practitioners selected by the employer pursuant to Section 12 of this Act and the time and place of any examination scheduled to be made pursuant to such Section.

Any employer who does not timely file and serve a written response without good cause may not introduce any evidence to dispute any claim of the employee but may cross examine the

employee or any witness brought by the employee and otherwise be heard.

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

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

All service required pursuant to this paragraph (b-1) must be by personal service or by certified mail and with evidence of receipt. In addition for the purposes of this paragraph, all service on the employer must be at the premises where the accident occurred if the premises are owned or operated by the employer. Otherwise service must be at the employee's

principal place of employment by the employer. If service on the employer is not possible at either of the above, then service shall be at the employer's principal place of business. After initial service in each case, service shall be made on the employer's attorney or designated representative.

(c)(1) At a reasonable time in advance of and in connection with the hearing under Section 19(e) or 19(h), the Commission may on its own motion order an impartial physical or mental examination of a petitioner whose mental or physical condition is in issue, when in the Commission's discretion it appears that such an examination will materially aid in the just determination of the case. The examination shall be made by a member or members of a panel of physicians chosen for their special qualifications by the Illinois State Medical Society. The Commission shall establish procedures by which a physician shall be selected from such list.

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

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

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

(5) The examination shall be made, and the physician or

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

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

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

(e) This paragraph shall apply to all hearings before the Commission. Such hearings may be held in its office or elsewhere as the Commission may deem advisable. The taking of

testimony on such hearings may be had before any member of the Commission. If a petition for review and agreed statement of facts or transcript of evidence is filed, as provided herein, the Commission shall promptly review the decision of the Arbitrator and all questions of law or fact which appear from the statement of facts or transcript of evidence.

In all cases in which the hearing before the arbitrator is held after December 18, 1989, no additional evidence shall be introduced by the parties before the Commission on review of the decision of the Arbitrator. In reviewing decisions of an arbitrator the Commission shall award such temporary compensation, permanent compensation and other payments as are due under this Act. The Commission shall file in its office its decision thereon, and shall immediately send to each party or his attorney a copy of such decision and a notification of the time when it was filed. Decisions shall be filed within 60 days after the Statement of Exceptions and Supporting Brief and Response thereto are required to be filed or oral argument whichever is later.

In the event either party requests oral argument, such argument shall be had before a panel of 3 members of the Commission (or before all available members pursuant to the determination of 7 members of the Commission that such argument be held before all available members of the Commission) pursuant to the rules and regulations of the Commission. A panel of 3 members, which shall be comprised of

not more than one representative citizen of the employing class and not more than one representative from a labor organization recognized under the National Labor Relations Act or an attorney who has represented labor organizations or has represented employees in workers' compensation cases, 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 every officer, board, commission, agency, public institution of higher learning, and fund administered by the treasurer ex officio, and every ~~Every~~ county, city, town, township, incorporated village, school district, body politic or municipal corporation against whom the Commission shall have rendered an award for the payment of money shall not be required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons.

The court may confirm or set aside the decision of the Commission. If the decision is set aside and the facts found in the proceedings before the Commission are sufficient, the court may enter such decision as is justified by law, or may remand the cause to the

Commission for further proceedings and may state the questions requiring further hearing, and give such other instructions as may be proper. Appeals shall be taken to the Appellate Court in accordance with Supreme Court Rules 22(g) and 303. Appeals shall be taken from the Appellate Court to the Supreme Court in accordance with Supreme Court Rule 315.

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

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

(g) Except in the case of a claim against the State of Illinois, either party may present a certified copy of the award of the Arbitrator, or a certified copy of the decision of the Commission when the same has become final, when no proceedings for review are pending, providing for the payment of compensation according to this Act, to the Circuit Court of the county in which such accident occurred or either of the parties are residents, whereupon the court shall enter a judgment in accordance therewith. In a case where the employer refuses to pay compensation according to such final award or such final decision upon which such judgment is entered the court shall in entering judgment thereon, tax as costs against

him the reasonable costs and attorney fees in the arbitration proceedings and in the court entering the judgment for the person in whose favor the judgment is entered, which judgment and costs taxed as therein provided shall, until and unless set aside, have the same effect as though duly entered in an action duly tried and determined by the court, and shall with like effect, be entered and docketed. The Circuit Court shall have power at any time upon application to make any such judgment conform to any modification required by any subsequent decision of the Supreme Court upon appeal, or as the result of any subsequent proceedings for review, as provided in this Act.

Judgment shall not be entered until 15 days' notice of the time and place of the application for the entry of judgment shall be served upon the employer by filing such notice with the Commission, which Commission shall, in case it has on file the address of the employer or the name and address of its agent upon whom notices may be served, immediately send a copy of the notice to the employer or such designated agent.

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

However, as to accidents occurring subsequent to July 1,

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

On such review, compensation payments may be re-established, increased, diminished or ended. The Commission shall give 15 days' notice to the parties of the hearing for review. Any employee, upon any petition for such review being filed by the employer, shall be entitled to one day's notice for each 100 miles necessary to be traveled by him in attending the hearing of the Commission upon the petition, and 3 days in addition thereto. Such employee shall, at the discretion of the Commission, also be entitled to 5 cents per mile necessarily traveled by him within the State of Illinois in attending such hearing, not to exceed a distance of 300 miles, to be taxed by the Commission as costs and deposited with the petition of the employer.

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

(i) Each party, upon taking any proceedings or steps

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

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

(k) In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional

to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay.

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

(l) If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 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. 101-384, eff. 1-1-20.)

Section 40. The Unemployment Insurance Act is amended by changing Section 1900 as follows:

(820 ILCS 405/1900) (from Ch. 48, par. 640)

Sec. 1900. Disclosure of information.

A. Except as provided in this Section, information obtained from any individual or employing unit during the administration of this Act shall:

1. be confidential,

2. not be published or open to public inspection,

3. not be used in any court in any pending action or proceeding,

4. not be admissible in evidence in any action or proceeding other than one arising out of this Act.

B. No finding, determination, decision, ruling, or order (including any finding of fact, statement or conclusion made therein) issued pursuant to this Act shall be admissible or used in evidence in any action other than one arising out of this Act, nor shall it be binding or conclusive except as provided in this Act, nor shall it constitute res judicata, regardless of whether the actions were between the same or related parties or involved the same facts.

C. Any officer or employee of this State, any officer or employee of any entity authorized to obtain information pursuant to this Section, and any agent of this State or of such entity who, except with authority of the Director under this Section or as authorized pursuant to subsection P-1, shall disclose information shall be guilty of a Class B misdemeanor and shall be disqualified from holding any appointment or employment by the State.

D. An individual or his duly authorized agent may be supplied with information from records only to the extent necessary for the proper presentation of his claim for benefits or with his existing or prospective rights to

benefits. Discretion to disclose this information belongs solely to the Director and is not subject to a release or waiver by the individual. Notwithstanding any other provision to the contrary, an individual or his or her duly authorized agent may be supplied with a statement of the amount of benefits paid to the individual during the 18 months preceding the date of his or her request.

E. An employing unit may be furnished with information, only if deemed by the Director as necessary to enable it to fully discharge its obligations or safeguard its rights under the Act. Discretion to disclose this information belongs solely to the Director and is not subject to a release or waiver by the employing unit.

F. The Director may furnish any information that he may deem proper to any public officer or public agency of this or any other State or of the federal government dealing with:

1. the administration of relief,

2. public assistance,

3. unemployment compensation,

4. a system of public employment offices,

5. wages and hours of employment, or

6. a public works program.

The Director may make available to the Illinois Workers' Compensation Commission <u>or the Department of Insurance</u> information regarding employers for the purpose of verifying the insurance coverage required under the Workers'

Compensation Act and Workers' Occupational Diseases Act.

G. The Director may disclose information submitted by the State or any of its political subdivisions, municipal corporations, instrumentalities, or school or community college districts, except for information which specifically identifies an individual claimant.

H. The Director shall disclose only that information required to be disclosed under Section 303 of the Social Security Act, as amended, including:

1. any information required to be given the United States Department of Labor under Section 303(a)(6); and

2. the making available upon request to any agency of the United States charged with the administration of public works or assistance through public employment, the name, address, ordinary occupation, and employment status of each recipient of unemployment compensation, and a statement of such recipient's right to further compensation under such law as required by Section 303(a)(7); and

3. records to make available to the Railroad Retirement Board as required by Section 303(c)(1); and

4. information that will assure reasonable cooperation with every agency of the United States charged with the administration of any unemployment compensation law as required by Section 303(c)(2); and

5. information upon request and on a reimbursable

basis to the United States Department of Agriculture and to any State food stamp agency concerning any information required to be furnished by Section 303(d); and

6. any wage information upon request and on a reimbursable basis to any State or local child support enforcement agency required by Section 303(e); and

7. any information required under the income eligibility and verification system as required by Section 303(f); and

8. information that might be useful in locating an absent parent or that parent's employer, establishing paternity or establishing, modifying, or enforcing child support orders for the purpose of a child support enforcement program under Title IV of the Social Security Act upon the request of and on a reimbursable basis to the public agency administering the Federal Parent Locator Service as required by Section 303(h); and

9. information, upon request, to representatives of any federal, State, or local governmental public housing agency with respect to individuals who have signed the appropriate consent form approved by the Secretary of Housing and Urban Development and who are applying for or participating in any housing assistance program administered by the United States Department of Housing and Urban Development as required by Section 303(i).

I. The Director, upon the request of a public agency of

Illinois, of the federal government, or of any other state charged with the investigation or enforcement of Section 10-5 of the Criminal Code of 2012 (or a similar federal law or similar law of another State), may furnish the public agency information regarding the individual specified in the request as to:

1. the current or most recent home address of the individual, and

2. the names and addresses of the individual's employers.

J. Nothing in this Section shall be deemed to interfere with the disclosure of certain records as provided for in Section 1706 or with the right to make available to the Internal Revenue Service of the United States Department of the Treasury, or the Department of Revenue of the State of Illinois, information obtained under this Act. With respect to each benefit claim that appears to have been filed other than by the individual in whose name the claim was filed or by the individual's authorized agent and with respect to which benefits were paid during the prior calendar year, the Director shall annually report to the Department of Revenue information that is in the Director's possession and may assist in avoiding negative income tax consequences for the individual in whose name the claim was filed.

K. The Department shall make available to the Illinois Student Assistance Commission, upon request, information in

the possession of the Department that may be necessary or useful to the Commission in the collection of defaulted or delinquent student loans which the Commission administers.

L. The Department shall make available to the State Employees' Retirement System, the State Universities Retirement System, the Teachers' Retirement System of the State of Illinois, and the Department of Central Management Services, Risk Management Division, upon request, information in the possession of the Department that may be necessary or useful to the System or the Risk Management Division for the purpose of determining whether any recipient of a disability benefit from the System or a workers' compensation benefit from the Risk Management Division is gainfully employed.

M. This Section shall be applicable to the information obtained in the administration of the State employment service, except that the Director may publish or release general labor market information and may furnish information that he may deem proper to an individual, public officer, or public agency of this or any other State or the federal government (in addition to those public officers or public agencies specified in this Section) as he prescribes by Rule.

N. The Director may require such safeguards as he deems proper to insure that information disclosed pursuant to this Section is used only for the purposes set forth in this Section.

O. Nothing in this Section prohibits communication with an

individual or entity through unencrypted e-mail or other unencrypted electronic means as long as the communication does not contain the individual's or entity's name in combination with any one or more of the individual's or entity's entire or partial social security number; driver's license or State identification number; credit or debit card number; or any required security code, access code, or password that would permit access to further information pertaining to the individual or entity.

P. (Blank).

P-1. With the express written consent of a claimant or employing unit and an agreement not to publicly disclose, the Director shall provide requested information related to a claim to an elected official performing constituent services or his or her agent.

Q. The Director shall make available to an elected federal official the name and address of an individual or entity that is located within the jurisdiction from which the official was elected and that, for the most recently completed calendar year, has reported to the Department as paying wages to workers, where the information will be used in connection with the official duties of the official and the official requests the information in writing, specifying the purposes for which it will be used. For purposes of this subsection, the use of information in connection with the official duties of an official does not include use of the information in connection

with the solicitation of contributions or expenditures, in money or in kind, to or on behalf of a candidate for public or political office or a political party or with respect to a public question, as defined in Section 1-3 of the Election Code, or in connection with any commercial solicitation. Any elected federal official who, in submitting a request for information covered by this subsection, knowingly makes a false statement or fails to disclose a material fact, with the intent to obtain the information for a purpose not authorized by this subsection, shall be guilty of a Class B misdemeanor.

R. The Director may provide to any State or local child support agency, upon request and on a reimbursable basis, information that might be useful in locating an absent parent or that parent's employer, establishing paternity, or establishing, modifying, or enforcing child support orders.

S. The Department shall make available to a State's Attorney of this State or a State's Attorney's investigator, upon request, the current address or, if the current address is unavailable, current employer information, if available, of a victim of a felony or a witness to a felony or a person against whom an arrest warrant is outstanding.

T. The Director shall make available to the Illinois State Police, a county sheriff's office, or a municipal police department, upon request, any information concerning the current address and place of employment or former places of employment of a person who is required to register as a sex

offender under the Sex Offender Registration Act that may be useful in enforcing the registration provisions of that Act.

U. The Director shall make information available to the Department of Healthcare and Family Services and the Department of Human Services for the purpose of determining eligibility for public benefit programs authorized under the Illinois Public Aid Code and related statutes administered by those departments, for verifying sources and amounts of income, and for other purposes directly connected with the administration of those programs.

V. The Director shall make information available to the State Board of Elections as may be required by an agreement the State Board of Elections has entered into with a multi-state voter registration list maintenance system.

W. The Director shall make information available to the State Treasurer's office and the Department of Revenue for the purpose of facilitating compliance with the Illinois Secure Choice Savings Program Act, including employer contact information for employers with 25 or more employees and any other information the Director deems appropriate that is directly related to the administration of this program.

X. The Director shall make information available, upon request, to the Illinois Student Assistance Commission for the purpose of determining eligibility for the adult vocational community college scholarship program under Section 65.105 of the Higher Education Student Assistance Act.

Y. Except as required under State or federal law, or unless otherwise provided for in this Section, the Department shall not disclose an individual's entire social security number in any correspondence physically mailed to an individual or entity.

(Source: P.A. 101-315, eff. 1-1-20; 102-26, eff. 6-25-21; 102-538, eff. 8-20-21; revised 11-8-21.)

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

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Statutes amended in order of appearance