

**ILLINOIS WORKERS' COMPENSATION COMMISSION**

**HANDBOOK ON  
WORKERS'  
COMPENSATION  
AND  
OCCUPATIONAL  
DISEASES**

**FOR INJURIES AND ILLNESSES  
FROM 2/1/06 – 6/27/11**



This handbook is designed to serve as a general guide to the rights and obligations of employees who have experienced work-related injuries or diseases, as well as the rights and obligations of their employers, under the Illinois Workers' Compensation and Occupational Diseases Acts.

**This handbook refers only to those injuries or illnesses that occurred on or after February 1, 2006.** If you need information for an earlier case, please refer to the previous version of the handbook, available on our website and in our offices.

No book can address all the situations that may occur. Benefits are determined by applying the law to the facts of each case. If you still have questions, please contact one of the Commission offices.

### COMMISSION OFFICES

Toll-free:	Within Illinois only	866/352-3033
Chicago:	100 W. Randolph St., #8-200, 60601	312/814-6611
Collinsville:	1014 Eastport Plaza Dr., 62234	618/346-3450
Peoria:	401 Main Street, Ste 640, 61602	309/671-3019
Rockford:	200 S. Wyman, 61101	815/987-7292
Springfield:	4500 S. Sixth St. Frontage Road, 62703	217/785-7087
TDD:	Telecomm. Device for the Deaf	312/814-2959

**This book is also available in Spanish.** Both versions of this handbook, as well as the statute, rules, and forms are available for free at each Commission office and on the website: [www.iwcc.il.gov](http://www.iwcc.il.gov).

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## CHAPTER 1

### Overview

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1. *What is workers' compensation?*

Workers' compensation is a system of benefits provided by law to most workers who have job-related injuries or diseases. These benefits are paid regardless of fault.

Each state has its own workers' compensation law. Illinois' law first took effect in 1912.

2. *Who administers the program?*

In 1913, the legislature created a state agency to resolve disputes between injured workers and their employers regarding workers' compensation. It has been known by different names over the years, but is now called the Illinois Workers' Compensation Commission.

As the administrative court system, the Commission must be impartial. Staff will explain procedures and basic provisions of the law, but cannot act as an advocate for either the employee or employer.

3. *Which employees are covered by the law?*

Almost every employee who is hired, injured, or whose employment is localized in the state of Illinois is covered by the law. These employees are covered from the moment they begin their jobs.

4. *What injuries and diseases are covered under the law?*

In most instances, the law covers injuries that are caused, in whole or in part, by the employee's work.

A worker injured by the repetitive use of a part of the body is covered, as is a person who experiences a stroke, heart attack, or other physical problem caused by work.

A worker who had a pre-existing condition may receive benefits if he or she can show the work aggravated that condition.

Injuries suffered in employer-sponsored recreational programs (e.g., athletic events, parties, picnics) are not covered unless the employee is ordered by the employer to participate. Accidental injuries

incurred while participating as a patient in a drug or alcohol rehabilitation program are not covered.

5. *What benefits are provided?*

The law provides the following benefit categories, which are explained in later chapters:

- a) Medical care that is reasonably required to cure or relieve the employee of the effects of the injury;
- b) Temporary total disability (TTD) benefits while the employee is off work, recovering from the injury;
- c) Temporary partial disability (TPD) benefits while the employee is recovering from the injury but working on light duty;
- d) Vocational rehabilitation/Maintenance benefits are provided to an injured worker who is participating in an approved vocational rehabilitation program;
- e) Permanent partial disability (PPD) benefits for an employee who sustains a permanent disability or disfigurement, but can work;
- f) Permanent total disability (PTD) benefits for an employee who is rendered permanently unable to work;
- g) Death benefits for surviving family members.

6. *Are workers' compensation benefits considered income?*

No. Workers' compensation benefits are not taxable under state or federal law and need not be reported as income on tax returns.

7. *Who pays for the benefits?*

By law, the employer is responsible for the cost of workers' compensation. Most employers buy commercial workers' compensation insurance, and the insurance company pays the benefits on the employer's behalf. No part of the workers' compensation insurance premium or benefit can be charged to the employee. Other employers obtain the state's approval to self-insure.

To identify the party responsible for paying benefits, an employee may check the employer's workplace notice, check the Commission's website, or contact the Commission's Insurance Compliance Division ([inscompquestions.wcc@illinois.gov](mailto:inscompquestions.wcc@illinois.gov); toll-free 866/352-3033).

8. *What does the law require of employers?*

Employers must:

- a) Obtain workers' compensation insurance or obtain permission to self-insure;
- b) Post a notice in each workplace that explains workers' rights under the Workers' Compensation Act and lists the insurance carrier, policy number, contact information, etc.;
- c) Keep records of work-related injuries and report to the Commission those accidents involving more than three lost work days;
- d) NOT charge the employee for any part of the workers' compensation insurance premium or benefits;
- e) NOT harass, discharge, refuse to rehire, or in any way discriminate against an employee for exercising his or her rights under the law.

9. *What if the employer does not have workers' compensation insurance?*

The employee should give the employer's name and address, and the date of injury, to the Commission's Insurance Compliance Division ([inscompquestions.wcc@illinois.gov](mailto:inscompquestions.wcc@illinois.gov); toll-free 866/352-3033).

An employer that *negligently* fails to provide coverage is guilty of a Class A misdemeanor for each day without coverage, punishable by up to 12 months imprisonment and a \$2,500 fine.

An employer that *knowingly* fails to provide coverage is guilty of a Class 4 felony for each day without coverage, punishable by 1-3 years imprisonment and a \$25,000 fine.

An uninsured employer may be also fined up to \$500 for every day it lacked insurance, with a minimum \$10,000 fine.

An uninsured employer loses the protections of the Workers' Compensation Act for the period of noncompliance. That means an employee who was injured during the period of noncompliance may choose to sue in civil court, where there are no limits to awards.

In addition, if the Commission finds that an employer knowingly failed to provide insurance coverage, it may issue a stop-work order and shut the company down until it obtains insurance.

Fines collected under these provisions are deposited into the Injured Workers' Benefit Fund, which are then distributed, on a pro rata basis, to injured workers whose uninsured employers failed to pay benefits.

10. *What is done to fight fraud?*

It is illegal for anyone—a worker, employer, insurance carrier, medical provider, etc.—to intentionally do any of the following:

- Make a false claim for any w.c. benefit;
- Make a false statement in order to obtain or deny benefits;
- Make a false statement in order to prevent someone from filing a legitimate claim;
- Make a false certificate of insurance as proof of insurance;
- Make a false statement in order to obtain w.c. insurance at less than the proper rate;
- Make a false statement in order to obtain approval to self-insure or reduce the security required to self-insure;
- Make a false statement to the state's fraud and noncompliance investigation staff in the course of an investigation;
- Help someone commit any of the crimes listed above;
- Move, destroy, or conceal assets so as to avoid payment of a claim.

A "statement" includes any writing, notice, proof of injury, or any medical bill, record, report, or test result.

Anyone found guilty of any of these actions is guilty of a Class 4 felony, punishable by 1-3 years imprisonment and a \$25,000 fine. The guilty party shall be required to pay complete restitution, and may be found civilly liable for up to three times the value of benefits or insurance coverage that was wrongfully attained.

If you wish to report a possibly fraudulent situation, you may contact the Workers' Compensation Investigative Unit at the Illinois Department of Financial and Professional Regulation/Division of Insurance ([francis.walsh@illinois.gov](mailto:francis.walsh@illinois.gov); 312/636-9457; toll-free 877/923-8648). You will be required to identify yourself and, at some point, the person you are reporting will be given your name. Anyone who intentionally makes a false report is guilty of a Class A misdemeanor, punishable by up to 12 months imprisonment and a \$2,500 fine.

## CHAPTER 2

### Reporting An Injury or Exposure

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1. *Who should the injured worker notify?*

The employee should inform the employer promptly. The law requires the employee to notify the employer of the date and place of the accident, if known.

Notice may be given orally or in writing. To avoid problems, we recommend the employee give the employer a written notice containing the following items:

- a) The date and place of the accident;
- b) A brief description of the accident, injury, or disease; and
- c) The employee's name, address, and telephone number.

Notice to a fellow worker who is not a part of management is not considered notice to the employer.

2. *What are the time limits for notifying the employer?*

Generally, the employee must notify the employer within 45 days of the accident. Any delay in the notice to the employer can delay the payment of benefits. A delay of more than 45 days may result in the loss of all benefits.

For injuries resulting from radiological exposure, the employee must notify the employer 90 days after the employee knows or suspects that he or she has received an excessive dose of radiation.

For occupational diseases, the employee must notify the employer as soon as practicable after he or she becomes aware of the condition.

3. *What should the employer do after receiving notice?*

The employer should promptly take the following steps:

- a) Provide all necessary first aid and medical services;
- b) Inform the insurance carrier or w.c. administrator, even if the employer doubts the employee's claim;
- c) If the employee cannot work for more than three days because of the injury, the employer must do one of the following:
  - (i) Begin payments of TTD; or

- (ii) Give the employee a written explanation of the additional information the employer needs before it will begin payments; or
- (iii) Give the employee a written explanation of why benefits are being denied.

4. *What records must the employer maintain?*

Employers must:

- a) Post a notice in each workplace that explains workers' rights under the Workers' Compensation Act and lists the insurance carrier, policy number, contact information, etc.
- b) Maintain accurate records of work-related deaths, injuries, or illnesses (other than minor injuries requiring only first aid and not involving further medical treatment, loss of consciousness, restriction of work or motion, or transfer to another job).
- c) Report accidents to the Commission on the form, "Employer's First Report of Injury" (Form 45).

Written reports of all job-related deaths must be made to the Commission within two working days.

Written reports of job-related injuries or illnesses resulting in the loss of more than three scheduled work days must be made within one month.

5. *What if the employer won't pay the worker any benefits?*

The worker or the worker's attorney should contact the employer directly to determine why benefits are not being paid. Poor communication often causes delays and misunderstanding.

If the problem persists, the employee should file a claim at the Commission. Please note that an accident report does not trigger any action by the Commission. The Commission gets involved only if the worker files a claim and follows the procedures to request a hearing. (See next chapter.)

6. *Can a worker be fired for reporting an accident or filing a claim?*

It is illegal for an employer to harass, discharge, refuse to rehire, or in any way discriminate against an employee for exercising his or her

rights under the law. Such conduct by the employer may give rise to a right to file a separate suit for damages in the circuit court.

An employee with a pending workers' compensation claim may still be disciplined or fired for other valid reasons.

**CHAPTER 3**  
**Filing a Claim at the Commission**

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1. *How is a claim opened at the Commission?*

The worker must file three copies of the *Application for Adjustment of Claim*, along with a *Proof of Service* stating that a copy of the application was given to the employer. Claims may be filed by mail or in person at any Commission office.

There are no fees for the forms or to file a claim.

2. *What happens after a claim is filed?*

The Commission assigns a case number and an arbitrator to the case. In Cook County, cases are randomly assigned among the Chicago arbitrators; downstate, cases are assigned to the hearing site closest to the site of the accident.

The case is set on an automatic two-month cycle. Every two months, the case is set for a status call. At the call, the parties may request a trial. If neither party requests a trial, the case is continued for another two months.

This rotation continues for three years. For the first three years after a case is filed, it is the parties' responsibility to move the case along. After three years, the arbitrator may dismiss the case unless the parties show there is a good reason to continue it.

It is important to realize that each arbitrator is responsible for thousands of cases, cannot monitor individual cases, and has no information as to whether benefits are or are not being paid. It is the parties' responsibility to track the case and take action when appropriate.

3. *Must an employee file a claim to receive benefits?*

If the employee wants the Commission to order benefits to be paid, he or she must file a claim.

An employee who is receiving benefits but is concerned about protecting his or her rights to receive future benefits may also wish to file a claim.

4. *What are the time limits for filing a claim?*

Generally, an employee who fails to file a claim within the time limits loses his or her right to claim future benefits.

In most cases, the employee must file a claim within three years after an injury, death, or disablement from an occupational disease, or within two years of the last payment of TTD or a medical bill, whichever is later.

Some cases have different deadlines:

Asbestos exposure: file within 25 years after the last exposure.

Death: file within three years of the death, within two years of the date of last compensation payment under the Workers' Compensation Act, or within three years of the date of last compensation payment under the Occupational Diseases Act, whichever is later.

Occupational disease: In most cases, unless an occupational disease causes a disablement within two years of the date of last exposure, no compensation is payable. For berylliosis or diseases caused by the inhalation of silica or asbestos dust, disablement must occur within three years from the last exposure to be compensable.

Pneumoconiosis: file within 5 years after the last exposure or last payment.

Radiation exposure: file within 25 years after the last exposure.

5. *Does the voluntary payment of benefits affect a claim?*

If the employee accepts benefits, he or she does not give up any rights under the law. Similarly, if the employer pays benefits, it does not waive its right to dispute the claim. Even if a claim is filed with the Commission after some benefits have been paid, the employer still has the right to contest its liability to pay any compensation at all.

6. *Does the worker have to hire an attorney to file a claim?*

No, but in disputed cases, most employees and employers do hire attorneys.

If the worker does not hire an attorney, it becomes the worker's responsibility to keep track of the claim, appear at hearings when

necessary, and present evidence at hearings that proves his or her eligibility under the law.

Arbitrators and commissioners must be neutral. They cannot act as an advocate for the worker or for the employer.

The Commission cannot recommend attorneys. People who want to retain legal counsel may wish to ask friends for a recommendation or call an attorney referral service. The Commission has a list of bar associations that make referrals.

7. *How much can an attorney charge?*

The law limits the attorney's fee:

- a) An attorney shall not charge any fee on payments the employer voluntarily made in a timely and proper manner for medical care, TTD, and any other compensation.
- b) The attorney's fee is limited to 20% of compensation recovered, up to 20% of 364 weeks of the maximum TTD benefit, unless a hearing is held and the Commission approves additional fees.
- c) If the employer made a written offer to the employee, the attorney may only charge a fee on the amount recovered in excess of this offer. In this case, the attorney's fee may exceed 20% of the additional amount recovered.
- d) The attorney's fee must be stated on the *Attorney Representation Agreement* form, signed by the employee (or in death cases, by the beneficiaries) and approved by the Commission.

8. *What if the worker is dissatisfied with the lawyer?*

The Commission cannot resolve problems between an injured worker and his or her lawyer. The claimant may try to improve the relationship with the lawyer, hire another lawyer, or proceed without a lawyer.

We encourage lawyers to keep their clients informed. We encourage claimants to educate themselves and follow the progress of the case.

**CHAPTER 4**  
**Resolving a Dispute At the Commission**

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1. *What must the worker do to receive benefits?*

It is the worker's responsibility to prove he or she is eligible for benefits. The employer does not need to disprove a worker's claim. By law, the burden of proof rests with the employee.

Some of the main issues in a workers' compensation case are listed below. The employee must prove all of them to qualify for benefits.

- a) Jurisdiction: on the date of the accident, the employer was subject to the Illinois Workers' Compensation or Occupational Diseases Act.
- b) Employment: on the date of the accident, a relationship of employee and employer existed between the parties.
- c) Accident or exposure: the worker sustained accidental injuries or was exposed to an occupational disease that arose out of and in the course of employment.
- d) Causal connection: the medical condition was caused or aggravated by the alleged accident or exposure.
- e) Notice: the employer received notice of the accident or exposure within the time limits set by law.

If the worker prevails on these issues, he or she will generally qualify for some benefit, but there may be other issues in dispute: for example, the parties may disagree over the extent of the worker's disability, or the worker's average weekly wage, or whether the medical treatments and/or bills were reasonable and necessary, or whether the worker is entitled to penalties, etc.

2. *How are disputes resolved?*

An arbitrator of the Commission will conduct a trial, relying on Illinois law, rules of evidence, precedents set by previous workers' compensation cases, and the *Rules Governing Practice Before the Commission*. A court reporter will make a record of the hearing.

Except for emergency hearings, an arbitrator cannot resolve a case until the worker has finished healing. Once the worker has healed, the parties need to prepare the case for trial by obtaining medical

records, doctors' depositions, and other paperwork. By the time everything is ready for trial, it is not uncommon for one to two years have passed.

Once everything is ready for trial, the arbitrator will schedule a trial within the month that the parties request it. After the trial, the arbitrator will issue a decision within 60 days, stating the amount of benefits, if any, to which the employee is entitled.

3. *Is there a way to get a quicker decision if there is an emergency?*

Yes, if either lost-time benefits or medical bills are unpaid, a party may petition for an emergency hearing.

Under Section 19(b), a final decision will be issued within 180 days of the date the *Petition for Review* was filed.

An employee who claims to be owed medical or compensation benefits may file a 19(b) petition, regardless of whether the employee is working.

An employer that is paying TTD may also file a 19(b) petition, as long as it keeps paying TTD until:

- a) the arbitrator rules on the petition;
- b) the worker's medical provider releases him or her back to regular work; or
- c) the employee starts work of any kind.

If there is a dispute about the insurance coverage for a case, an insurance carrier, private self-insured employer, or group w.c. pool may file a 19(b) petition, as long as it keeps providing medical and/or TTD benefits.

Neither the employee nor the employer is entitled to a 19(b) hearing if the employee has returned to work and the only benefit in dispute amounts to less than 12 weeks of TTD.

Under Section 19(b-1), a final decision will be issued within 180 days, but it should be noted that there are many technical requirements to this process.

An employee who claims to be unable to work as the result of an injury and who is not receiving medical benefits or TTD may file a 19(b-1) petition to obtain a quick ruling on the medical care and/or TTD issues.

In both cases, once the issues contained in the emergency process are decided, the case will go back on the arbitration call to resolve other issues in dispute.

4. *Is it possible to appeal the arbitrator's decision?*

Yes. The employee and the employer each have the right to appeal a decision if dissatisfied. A panel of three commissioners (usually called the Commission) will review the arbitrator's decision, as well as the evidence and transcript of the trial. Both sides may submit written arguments to the Commission. The Commission will then conduct a hearing (called an oral argument) at which the parties may present a brief, 5-10 minute argument for their position. Within 60 days of that hearing, the Commission will issue its decision.

While an appeal is pending, the employer does not have to pay the benefits awarded by the arbitrator. If the case is ultimately resolved completely in the worker's favor, interest will be added to the award, based on governmental bond rates at the time of the decision. There is also a 1% per month interest charge on medical bills, payable to the medical provider.

Commission decisions are final for cases involving employees of the State of Illinois. In all other cases, either party may appeal to the Circuit Court, the Appellate Court, and in some cases, to the Illinois Supreme Court. A chart at the end of this chapter illustrates the process.

There is a higher standard of review in the courts. Generally, a court will not reverse a Commission decision unless it finds that the decision is against the manifest weight of the evidence.

5. *Is there any other way to resolve disputes?*

As in other court systems, most cases are resolved through a compromise settlement between the parties. A settlement is a contract between the employee and the employer to close a claim in exchange for an agreed-upon amount of money.

By settling a case, the employee avoids the risk of getting no compensation or less than is provided in the settlement, and the employer avoids the risk of paying more. Usually, cases are resolved quicker by settlement than by trial. On average, a settlement is approved 1 1/2 years after a claim is filed.

If the employer and employee reach agreement, they should write down the terms of their agreement on the Commission's *Settlement Contract* and present it for approval to the arbitrator assigned to the case. A settlement is not legally binding unless the Commission approves it.

An approved settlement contract generally closes out the employee's rights to any future cash or medical benefits, even if his or her condition worsens. If the parties want to keep a benefit open, this should be clearly stated in the settlement contract.

An employee who does not have an attorney (called a "pro se" petitioner) must appear in person before the arbitrator who, before approving it, will review the settlement and make sure it is fair and that the employee understands its effect. Note that the arbitrator will act as a neutral judge, not as the worker's advocate.

A settlement that is made without Commission approval does not close out the employee's rights, and the time in which an employee may file a claim with the Commission is extended indefinitely.

Any settlement contract made within seven days of the injury is presumed to be fraudulent.

6. *Does a decision or settlement close a case forever?*

A settlement usually closes a case forever unless the parties specifically state otherwise in the agreement. The following changes may occur after a decision or settlement is issued:

- a) At any time after a decision, the employee may request additional medical services that are reasonably required to cure or relieve the effects of the injury or disease. If the employer does not agree to the request, the employee may file a petition asking the Commission to resolve the dispute.
- b) Within 30 months after the Commission issues a decision or approves a settlement contract payable in installments, if an employer can show that the disability has decreased, it may file a petition for a reduction in benefits. Conversely, if an employee can show that the disability has increased, he or she may file a petition for additional benefits.
- c) Within 60 months after the Commission issues a decision or approves a settlement contract payable in installments for wage differential benefits, if an employer can show that the disability has decreased, it may file a petition for a reduction in benefits.

Conversely, if an employee can show that the disability has increased, he or she may file a petition for an increase in benefits.

- d) Anytime after the Commission issues a decision for permanent total disability, if the employer can show that the employee is no longer totally disabled, the employer may petition the Commission for an order terminating the PTD payments.

7. *What if the Commission awards benefits, but the employer won't pay?*

The employee may take one or more of the following actions:

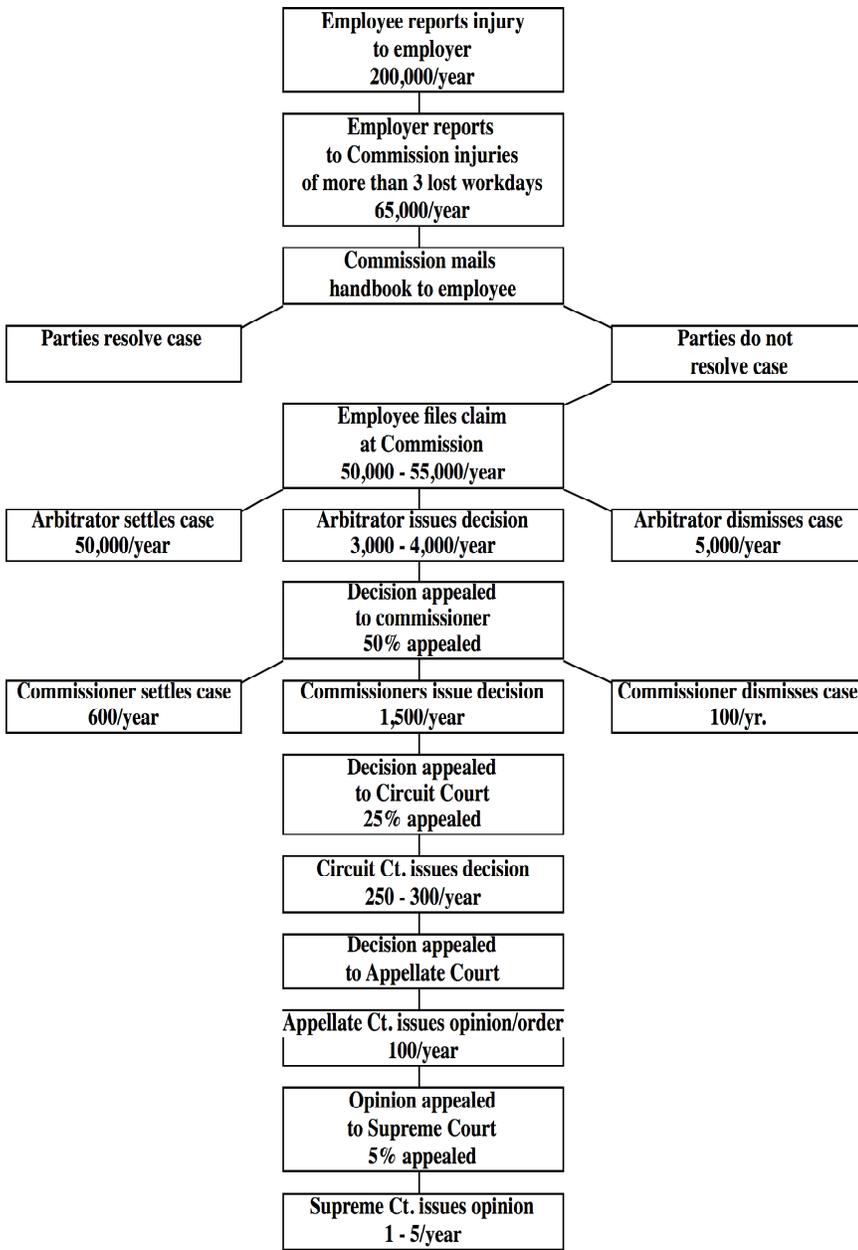
- a) File a petition in the circuit court, asking the court to order payment under Section 19(g) of the act;
- b) File a petition with the Commission for penalties and/or attorneys' fees for delay in payment, as appropriate, under Sections 16, 19(k), and/or 19(l) of the act;
- c) File a petition with the Commission alleging a policy of delay or unfairness by the insurer or self-insurer under Section 4(c) of the act;
- d) Call the Consumer Services Division of the Illinois Department of Financial and Professional Regulation/Division of Insurance (toll-free 866/445-5364 or 217/782-4515).

8. *Where are hearings held?*

Arbitrators hold hearings at 24 sites around the state. Cases are assigned to the hearing site nearest the site of the accident. If the accident occurred outside of Illinois, the case is assigned to the hearing site closest to the worker's home. If the petitioner lives outside of Illinois, the case is assigned to the site most convenient to the parties.

Commissioners hold oral arguments in Springfield and Chicago.

## Flow Chart of Dispute Resolution Process



Note: Cases can go back and forth between levels. Figures are rough estimates.

## CHAPTER 5

### Medical Benefits

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1. *What medical benefits are covered under the law?*

The employer is required to pay for all medical care that is reasonably necessary to cure or relieve the employee from the effects of the injury.

This includes but is not limited to first aid, emergency care, doctor visits, hospital care, surgery, physical therapy, chiropractic treatment, pharmaceuticals, prosthetic devices, and prescribed medical appliances.

The cost of devices, such as a shoe lift or a wheelchair, may be covered. If the work injuries result in a disability that requires physical modifications to the worker's home, such as a wheelchair ramp, the employer may have to pay those costs, as well.

2. *Who pays for the medical care?*

If the employer does not dispute a medical bill, it will pay the medical provider directly. The worker is not required to pay co-payments or deductibles.

If the employer disputes a bill, it must promptly give the worker a written explanation for its refusal.

While a case is pending at the Commission, the provider cannot try to collect payment from the employee once the employee notifies the provider that he or she has filed a claim with the Commission to resolve this dispute.

The provider may send the employee reminders of the outstanding bill, and ask for information about the case (e.g., case number, status of case). If the employee does not provide the information within 90 days of the date of the reminder, the provider may resume its efforts to collect payment.

3. *Can the employee choose the treating doctor or hospital?*

Yes, but there are limits. The employee is entitled to choose two medical providers and any other providers to whom the employee is referred.

That means an employee may initially choose any doctor or hospital, even if the provider is outside the employee's regular insurance network, and go to any doctor to whom the employee is referred by that provider.

If desired, the employee may then choose another doctor or hospital, and again go to any doctor to whom the employee is referred by the provider.

Generally, if the employee chooses a third doctor without the employer's approval, the employer is not required to pay for those services.

First aid and emergency care are not considered to be one of the worker's two choices.

4. *As long as the worker stays within the limits on choice of provider, will the employer then pay for all medical care?*

A utilization review organization may review the employee's past, present, and future medical treatments related to the work injury, and analyze the necessity of those treatments. The Commission will consider the utilization review finding, along with all other evidence, when determining whether a treatment was reasonably necessary. If the Commission finds a medical treatment was not reasonably necessary, it will not order the employer to pay the bill, and the employee may be responsible for it.

5. *What are the worker's responsibilities regarding medical care?*

The worker should take the following steps:

- a) Seek first aid or medical attention immediately after the injury or the point at which gradual symptoms first begin affecting physical activities at work or at home. (Under some circumstances, the employee may rely upon treatment by prayer or spiritual means alone.)
- b) Cooperate with the doctors and make efforts to achieve a complete recovery and full return to work, if possible. A worker may lose benefits for injurious or unsanitary activities.
- c) Tell the medical providers that the treatment is for a work-related condition. This lets the providers know that the employer is responsible for the medical bill.

- d) Give the employer the name and address of the doctor or hospital chosen. If the employee changes providers, the employee should again notify the employer.

The employee must also give the employer enough medical information for the employer to determine whether to accept or deny the claim. This includes all medical records relevant to the condition for which benefits are sought. A worker is not required to give anyone free access to his or her doctor or medical records, however.

The employer is not required to provide benefits if it does not receive the medical information necessary to determine the worker's medical status and fitness to work. If the employee's doctor does not send medical records to the employer, benefits may be delayed.

6. *Does a worker have to allow employer-hired case managers to manage his or her care?*

No. A worker may, without penalty, refuse or limit the involvement of nurses or case managers hired by the employer. The employee is obligated to provide medical records that are relevant to the case, but otherwise a worker's medical care is confidential.

While case management is not mandatory, if a case is complicated or the injury severe, a worker may find the assistance of case management helpful.

7. *Can the employer ask for an evaluation by its own doctor?*

Yes. On occasion, the employer may request a full medical exam by the doctor of its choice. When the employer gives the employee notice of the place and time of the exam, it must at the same time give the employee money to cover travel expenses, meals, lost wages, etc.

The exam must be held at a reasonable time and place. The worker must undergo the exam, but he or she need not accept any treatment from the employer's doctor.

The employer's doctor must give both parties the same report of the exam as soon as practicable, but not less than 48 hours before an arbitration hearing.

The worker is also entitled, upon request, to a copy of all relevant medical records in the employer's possession.

8. *How are prices for medical care determined?*

Most treatments that are covered under the Act and were provided on or after February 1, 2006 are subject to a medical fee schedule. The employer shall pay the lesser of the provider's actual charge or the amount set by the fee schedule.

If, however, an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in the contract shall prevail.

The schedule is posted on the Commission's website. Please also refer to the law, rules, *Instructions and Guidelines*, and the "Frequently Asked Medical Questions" web page.

**CHAPTER 6**  
**Temporary Total Disability (TTD) Benefits**

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1. *What is temporary total disability (TTD)?*

TTD is the period in which an injured worker is either temporarily unable to return to any work, as indicated by his or her doctor, or is released to do light-duty work but whose employer is unable to accommodate him or her. The employer pays TTD benefits to an injured employee until the worker has returned to work or has finished healing.

2. *How is the TTD benefit calculated?*

The TTD benefit is two-thirds (66 2/3%) of the employee's average weekly wage, subject to minimum and maximum limits. The minimums and maximums are available in Commission offices and on the website ([www.iwcc.il.gov/benefits.htm](http://www.iwcc.il.gov/benefits.htm)).

3. *How is the employee's average weekly wage (AWW) calculated?*

The calculation of AWW can be complicated and will depend on the facts of each case. The following principles will generally apply.

The AWW is based on the employee's gross (pre-tax) wages during the 52 weeks before the date of injury or exposure.

If an employee had more than one job at the time of injury, the AWW may be based on the combined income from all jobs if the employer for whom the employee was working at the time of the injury knew he or she had other job(s).

If the worker was employed for fewer than 52 weeks, the AWW is calculated using the number of weeks he or she actually worked for that employer.

If the employee had worked for the employer for only a short time or on a casual basis, the Commission may consider what another person in the job with the same employer would have earned during the previous year.

Overtime pay is generally not included in the AWW calculation for cases filed under the Workers' Compensation Act unless the

overtime was regularly worked. Overtime pay is included for cases filed under the Occupational Diseases Act.

TTD benefits for volunteer fire fighters, police, and civil defense members or trainees are based on the AWW earned in their regular employment if the claim arises under the Workers' Compensation Act.

4. *What is the minimum TTD benefit?*

An employee's TTD benefit shall not be more than his or her AWW. The minimum TTD benefit is based on the greater of the state or federal minimum wage. The benefit rates are available in Commission offices and on the website.

5. *What is the maximum TTD benefit?*

The maximum TTD benefit is 133 1/3% of the statewide average weekly wage on the date of the injury. The benefit rates are available in Commission offices and on the website.

6. *Is there a waiting period for TTD?*

TTD is not paid for the first three lost work days, unless the employee misses 14 or more calendar days due to the injury.

7. *When is TTD paid?*

The employer should make the first TTD payment within 14 days after receiving notice of the injury. Since delays are common, to facilitate the prompt payment of benefits, we encourage the employee to give the employer a written demand for TTD benefits along with the doctor's note.

If the employer doesn't pay promptly and can't justify the delay, the employee may petition the arbitrator to order the employer to pay penalties and/or attorneys' fees to the worker.

The employer should pay TTD at the same interval the employee was paid before the injury (e.g., weekly or biweekly).

If an employer stops paying TTD before the employee returns to work, it must give the employee a written explanation no later than the date of the last TTD payment. If the employer fails to provide this explanation, the employee may petition the arbitrator to assess penalties and/or attorneys' fees.

**CHAPTER 7**  
**Temporary Partial Disability (TPD) Benefits**

---

1. *What is temporary partial disability (TPD)?*

TPD is the period in which an injured employee is still healing and is working light duty, on a part-time or full-time basis, and earning less than he or she would earn in the pre-injury job(s). The employer pays TPD benefits to an injured employee until the worker has returned to his or her regular job or has finished healing.

2. *How is the TPD benefit calculated?*

The TPD benefit is two-thirds (66 2/3%) of the difference between the average amount the worker would be able to earn in the pre-injury job(s) and the net amount he or she earns in the light-duty job.

Example:

A worker was earning \$500/week at the time of injury. While the worker was off work and recuperating, the pay for the job increased to \$525/week. The worker returns to a light-duty job and, after taxes are deducted, takes home \$200/week.

Pre-injury average weekly wage (AWW)	=	\$500		
Current AWW of pre-injury job	=	\$525		
Post-injury take-home pay	=	\$200		
Wage differential	=	\$525 - \$200	=	\$325
TPD	=	\$325 X 66 2/3%	=	\$216.67/week

## CHAPTER 8

### Vocational Rehabilitation/Maintenance Benefits

---

1. *What is vocational rehabilitation?*

Vocational rehabilitation includes but is not limited to counseling for job searches, supervising a job search program, and vocational retraining, including education at an accredited learning institution.

2. *When is the employee entitled to vocational rehabilitation?*

If the employee cannot return to the pre-injury job, the employer must pay for treatment, instruction, and training necessary for the physical, mental, and vocational rehabilitation of the employee, including all maintenance costs and incidental expenses. The employee must cooperate in a reasonable rehabilitation program.

The employee may choose the provider of such reasonable vocational rehabilitation services or may accept the services of a provider selected by the employer.

3. *What benefit is the employee entitled to while participating in an approved vocational rehabilitation program?*

An employee is entitled to maintenance benefits, plus costs and expenses incidental to the vocational rehabilitation program.

4. *How is the maintenance benefit calculated?*

The maintenance benefit shall not be less than the employee's TTD rate.

**CHAPTER 9**  
**Permanent Partial Disability (PPD) Benefits**

---

1. *What is permanent partial disability (PPD)?*

PPD is:

- a) The complete or partial loss of a part of the body; or
- b) The complete or partial loss of use of a part of the body; or
- c) The partial loss of use of the body as a whole.

“Loss of use” is not specifically defined in the law, but it generally means the employee is unable to do things he or she was able to do before the injury.

The Commission cannot make a PPD determination until the worker has finished healing. PPD is paid only if the job-related injury results in some permanent physical loss.

2. *What types of PPD benefits are there?*

There are four types of PPD benefits:

a. Wage differential (Section 8(d)1 of WC Act)

If, due to the injury, the employee obtains a new job that pays less than the pre-injury job(s), he or she may be entitled to receive a wage differential for the duration of the disability. The wage differential is two-thirds (66 2/3%) of the difference between the amount the worker earns in the new job and the amount he or she would be earning in the old job(s).

An employee may be compensated for either the loss of wages or the permanent disability related to the same injury, but not both.

Example:

A worker was earning \$1,000/week at the time of injury. While the worker was off work and recuperating, the pay for the job increased to \$1,040/week. Due to the injury, the worker can only find a job that pays \$500/week.

Pre-injury average weekly wage (AWW)	=	\$1,000	
Current AWW of pre-injury job	=	\$1,040	
AWW of post-injury job	=	\$500	
Wage differential	=	\$1,040 - \$500	= \$540
PPD benefit	=	\$540 X 66 2/3%	= \$360/week

b. Schedule of injuries (Section 8(e) of WC Act)

The law sets a value on certain body parts, expressed as a number of weeks of compensation for each part. (See the chart at the end of this chapter.) The number of weeks is then multiplied times 60% of the employee's AWW.

If a body part is amputated or if it cannot be used at all, that represents a 100% loss, and the employee is awarded the entire number of weeks listed on the chart. If the employee sustains a partial loss, the benefit is calculated by multiplying the percentage of loss by the number of weeks listed.

Example:

A worker earning \$500/week injures his or her thumb, and it is later determined there is a 10% loss of the use of the thumb.

PPD weekly rate	=	\$500 X 60%	=	\$300
Number of weeks	=	76 weeks X 10%	=	7.6
PPD benefit	=	7.6 weeks X \$300	=	\$2,280

c. Non-schedule injuries (person as a whole) (Section 8(d)2)

If the condition is not listed on the schedule of injuries, but it imposes certain limitations, the employee may be entitled to a percentage of 500 weeks of benefits, based on the loss of the person as a whole. The number of weeks is then multiplied times 60% of the employee's AWW.

Example:

A worker earning \$500/week suffers a back injury that is determined to have caused a 10% loss of the person as a whole.

PPD weekly rate	=	\$500 X 60%	=	\$300
Number of weeks	=	500 weeks X 10%	=	50 weeks
PPD benefit	=	50 weeks X \$300	=	\$15,000

d. Disfigurement (Section 8(c) of WC Act)

An employee who suffers a serious and permanent disfigurement to the head, face, neck, chest above the armpits, arm, hand, or leg below the knee, is entitled to a maximum of 162 weeks of benefits at the PPD rate. The number of weeks is then multiplied times 60% of the employee's AWW.

A scar must heal for at least six months before a hearing to assess the disfigurement can be held.

An employee may not collect compensation for disfigurement and the loss of use for the same body part. For example, a person who undergoes carpal tunnel surgery and is found to have experienced some loss of use, may be awarded a benefit based on the body part or on the disfigurement from the surgery scars, but not both.

3. *How is the level of disability assessed?*

On a case-by-case basis, the Commission evaluates the physical impairment and the effect of the disability on the injured worker's life. Factors that may be considered include the individual's age, skill, occupation, training, inability to engage in certain kinds of activities, pain, stiffness, or limitation of motion. Employees are not compensated for past pain and suffering, only for the residual pain that is part of the permanent disability.

4. *What is the minimum PPD benefit?*

The minimum PPD benefit for amputation or enucleation is 50% of the statewide average weekly wage (SAWW).

For all other PPD categories, an employee's PPD benefit shall not be more than his or her AWW. The benefit rates are available in Commission offices and on the website.

5. *What is the maximum PPD benefit?*

Wage differential cases: 100% of SAWW  
Amputation or enucleation: 133 1/3% of SAWW

By law, the maximum rate for the other three PPD categories (schedule of injuries, non-schedule injuries, and disfigurement) are calculated using a different formula, based on the rate of increase in the statewide average weekly wage. Please refer to the benefit rate sheets for this maximum.

6. *What if the worker's condition changes?*

For wage differential benefits: if the employee's physical condition changes during the 60 months after the award becomes final, either party may ask the Commission to adjust the award.

For all other PPD categories: if the employee's physical condition changes during the 30 months after the award becomes final, either party may ask the Commission to adjust the award.

**PERMANENT PARTIAL DISABILITY BENEFITS  
FOR 100% LOSS OF USE  
ON OR AFTER 2/1/06**

BODY PART	WEEKS PAID
Thumb	76
1st (index) finger	43
2nd finger	38
3rd finger	27
4th finger	22
Hand	205
Arm	253
Arm amputated above elbow	270
Arm amputated at shoulder joint	323
Toe (great toe)	38
Toe (each other toe)	13
Foot	167
Leg	215
Leg amputated above knee	242
Leg amputated at hip joint	296
Eye: loss of vision	162
Eye removal (enucleation)	173
Ear: hearing loss due to accident or trauma*	54
Ear: hearing loss due to occupational disease*	100
Ears (2)*	215
Kidney, spleen, or lung (removal)	10
Testicle (1)	54
Testicles (2)	162
Skull fracture	6+
Facial bone fracture	2+
Vertebra fracture	6+
Spine or transverse process fracture	3+

Loss of a part of the thumb, finger or toe up to the first joint from the tip is considered loss of one-half the digit, e.g., 38 weeks for half a thumb. Loss beyond the first joint is considered 100% loss of the digit.

\*A loss due to noise exposure may also be compensable, if the employee can show that he or she was exposed to certain noise levels for the durations specified in the law.

**CHAPTER 10**  
**Permanent Total Disability (PTD) Benefits**

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1. *What is permanent total disability (PTD)?*

PTD is either:

a) The permanent and complete loss of use of both hands, both arms, both feet, both legs, both eyes, or any two such parts, e.g., one leg and one arm;

or

b) A complete disability that renders the employee permanently unable to do any kind of work for which there is a reasonably stable employment market.

2. *What is the PTD benefit?*

A claimant who is found to be permanently and totally disabled is entitled to a weekly benefit equal to two-thirds ( $66\frac{2}{3}\%$ ) of his or her average weekly wage, subject to minimum and maximum limits, for life. The minimum and maximum benefit rates are available in Commission offices and on the website.

3. *Can a PTD recipient ever work?*

Generally, no. If an employee who experiences a complete disability (see 1(b) above) returns to work or is able to return to work, the employer may petition the Commission to terminate or modify the PTD benefit.

4. *Does the benefit amount stay fixed for life?*

There are cost-of-living adjustments if the case was closed by a decision. Beginning in the second year after the award was issued, the recipient will receive an amount from the Commission's Rate Adjustment Fund that reflects the increase in the statewide average weekly wage during the preceding year. These payments are made monthly.

5. *What is the minimum PTD benefit?*

The minimum PTD benefit is 50% of the statewide average weekly wage (SAWW) at the time of the injury. The benefit rates are available in Commission offices and on the website.

6. *What is the maximum PTD benefit?*

The maximum PTD benefit is 133 1/3% of the SAWW at the time of the injury. The benefit rates are available in Commission offices and on the website.

7. *Can an employee receive both PTD and Social Security?*

Yes, if the employee qualifies under the terms of each program. If an employee receives both benefits, the Social Security Administration will apply a formula that may result in a reduction in the Social Security benefit.

## CHAPTER 11

### Death/Survivors' Benefits

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1. *What is the burial benefit?*

A benefit of \$8,000 is provided to the survivor or the person paying for the burial.

2. *How is the amount of the survivors' benefit calculated?*

The benefit is two-thirds (66 2/3%) of the employee's gross average weekly wage during the 52 weeks before the injury, subject to minimum and maximum limits.

3. *Who is entitled to the survivors' benefit?*

There is a hierarchy of entitlement. The primary beneficiaries are the spouse and young children. If no primary beneficiaries exist, benefits may be paid to totally dependent parents. If no totally dependent parents exist, benefits may be paid to persons who were at least 50% dependent on the employee at the time of death.

4. *What if the surviving spouse remarries?*

If there are eligible children at the time of remarriage, benefits will continue.

If there are no eligible children at the time of remarriage, the spouse is entitled to a final lump sum payment equal to two years of compensation. All rights to further benefits are extinguished.

5. *What is the minimum survivors' benefit?*

The minimum survivors' benefit cannot be less than 50% of the statewide average weekly wage (SAWW) at the time of the injury, unless there is a reduction for partially dependent individuals.

6. *What is the maximum survivors' benefit?*

The maximum survivors' benefit can be no more than 133 1/3% of the SAWW at the time of the injury. The benefit is paid for 25 years of weekly benefits or \$500,000, whichever is more.

7. *Does the benefit amount stay fixed for life?*

There are cost-of-living adjustments if the case was closed by a decision. Beginning in the second year after the award was issued, the recipient will receive an amount from the Commission's Rate Adjustment Fund that reflects the increase in the statewide average weekly wage during the preceding year. These payments are made monthly.

## Glossary

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### **arbitrator**

The Illinois Workers' Compensation Commission (IWCC) employee who serves as the first-level hearing officer on a case.

### **average weekly wage (AWW)**

The calculation of an employee's gross (pre-tax) wages, on which benefits are based.

### **burial benefit**

A benefit of \$8,000, paid to the survivor or the person paying for the burial of a fatally-injured worker.

### **claim**

A case opened by a worker by filing the *Application for Adjustment of Claim* with the IWCC, which starts the Commission's court process in motion.

### **commissioner**

The IWCC officer who serves as the review-level hearing officer on a case.

### **disfigurement**

A serious and permanent worsening of appearance to the head, face, neck, chest above the armpits, arm, hand, or leg below the knee.

### **emergency hearing**

The process by which an employee who claims to be owed medical or compensation benefits may receive a quicker hearing.

### **employee choice**

The employee's legal right to choose two medical providers and any other providers to whom the employee is referred.

### **fee schedule**

A list of fees, rules, instructions, and guidelines regarding the payment for most treatments that are covered under the Act and were provided on or after February 1, 2006.

**Illinois Workers' Compensation Commission (IWCC)**

The state agency that resolves disputes between injured workers and their employers regarding workers' compensation.

**independent medical exam (also called a Section 12 exam)**

An exam of the employee, requested by the employer, by a doctor of its choice.

**maintenance**

The benefit provided to an employee who is participating in a vocational rehabilitation program.

**maximum medical improvement (MMI)**

The point at which an employee has finished healing from an injury and has become medically stationary.

**medical benefit**

Employer-paid medical care that is reasonably necessary to cure or relieve the employee from the effects of the injury.

**notice**

The oral or written communication from the employee to the employer, describing the date and place of an accident.

**permanent partial disability (PPD)**

The complete or partial loss of a part of the body; or the complete or partial loss of use of a part of the body; or the partial loss of use of the body as a whole.

**permanent total disability (PTD)**

The permanent and complete loss of use of both hands, both arms, both feet, both legs, both eyes, or any two such parts, e.g., one leg and one arm; or a complete disability that renders the employee permanently unable to do any kind of work for which there is a reasonably stable employment market.

**pro se**

A claimant who does not have an attorney.

**Rate Adjustment Fund**

The state fund that pays cost-of-living adjustments on PTD and fatal awards.

**schedule of injuries**

The value of certain body parts, expressed as a number of weeks of compensation for each part.

**settlement**

A contract between the employee and the employer to close a claim in exchange for an agreed-upon amount of money, approved by the Commission.

**statewide average weekly wage (SAWW)**

The figure, calculated by the Illinois Department of Employment Security, that sets the maximum and some minimum weekly w.c. benefit levels.

**temporary partial disability (TPD)**

The period in which an injured employee is still healing and is working light duty, on a part-time or full-time basis, and earning less than he or she would earn in the pre-injury job(s).

**temporary total disability (TTD)**

The period in which an injured worker is either temporarily unable to return to any work, as indicated by his or her doctor, or is released to do light-duty work but whose employer is unable to accommodate him or her.

**vocational rehabilitation**

Services provided to an employee who cannot return to the pre-injury job, which include but are not limited to counseling for job searches, supervising a job search program, and vocational retraining, including education at an accredited learning institution.

**wage differential**

The difference between the lower amount an employee earns, due to an injury, and the amount he or she would be earning in the pre-injury job(s).

**workers' compensation**

A no-fault system of benefits provided by law to workers who have job-related injuries or diseases.

**workplace notice**

A poster that employers must display in each workplace that explains workers' rights under the Illinois Workers' Compensation Act and lists the insurance carrier, policy number, contact information, etc.

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