information required, the insurer shall have...within 30 calendar days after the receipt, then they shall give the provider, the policyholder, the insured and patient a written explanation of the additional information that's needed. Then the person receiving a request for additional information shall comply within 30 days. After additional information is provided, the claim can be paid, denied, settled within the remaining applicable 30- or 45-day time period, and the insurer may deny a claim if a provider fails to submit additional information. Section 5 is a penalty section; provides that an insurer that fails to pay, deny or settle a claim, or take action within a specified amount of time will pay interest at the rate of 12 percent per annum on the total amount ultimately allowed on the claim, from the date payment was due. And Section 6 provides that an insurer may be exempt from insurance...interest, excuse me, when the insurer has a prompt pay act compliance statement on file with the Department of Insurance. Section 7: If an insurer delegates its claims processing to a third party--would be a claims administrator--the third party shall consent to examination by the director of Insurance and shall comply with this act. Section 8 is the teeth. This is...this is what makes this whole thing work. It says, first, that the director of Insurance will compile a record of notices from insured, representatives of insured, and healthcare providers acting on behalf of insured, related to unfair payment practices. So the department will keep a chronology and keep track of all complaints that it receives. Does not happen today. And then, secondly, if the director investigates and finds after a hearing that an insured or a third party has an unfair payment pattern, or the insured has falsely filed a prompt payment act compliance statement, the director shall issue a cease and desist order and may do one of these following things: The director could order payment of a penalty, not to exceed $1,000 for each violation, and an aggregate of $30,000. If the violation was flagrant, the payment will not be more than $15,000 for each violation, not to exceed an aggregate of $150,000. Those kind of dollars gain the attention of an insurance company. The director may also order suspension or revocation of the insurer's license or certificate of authority, and the director may withdraw the insurer's prompt payment act compliance statement. An insurer that violates a