Tax Man Goes Easy On Wal-Mart, But You Make Up The Difference

Wal-Mart sets up a "shell" company in a low-tax state to collect "rent" from its stores in higher-tax states. Wal-Mart's bookkeepers then deduct rent costs so they don't pay corporate income taxes on it. The plan enabled Wal-Mart to dodge an estimated $3.4 billion in state taxes between 1999 and 2005.

Another tax dodge available to big companies: Shifting costs to taxpayers and employees. Wal-Mart failed to provide health care coverage to over 775,000 of its workers and their families last year. When those families need health care, they enroll in Medicaid or just show up at emergency rooms for treatment. The result: taxpayers from working families will pay $9.1 billion over the next five years to cover Wal-Mart's health care costs.

Wal-Mart's tax dodge cost ordinary working families two ways: We pay the extra medical costs when Wal-Mart workers use public-funded health care, and we also lost out on the public services that would be available if Wal-Mart was paying its fair share. The study, **"America Pays, Wal-Mart Saves,"** documents a few of the things that Americans could have if not for tax dodgers like Wal-Mart, including:

*Health care coverage for 318,400 uninsured children.

*New Classrooms for 21,963 U. S. school children.

*9,499 additional police officers patrolling our streets.

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Handling Your Insurance Claims

A general guide to get the most from your insurance company - part 2

Filing a Claim

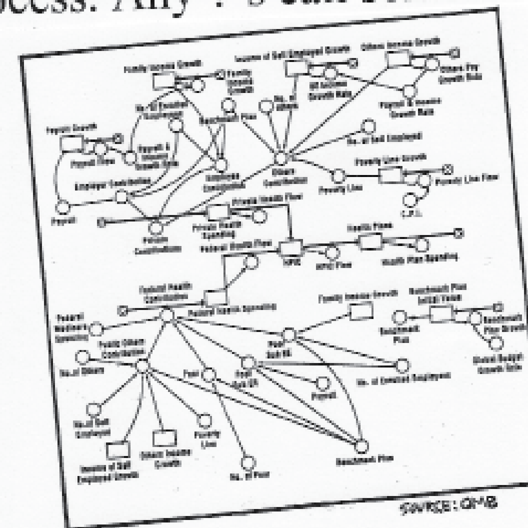
Make sure that you meet your plan's requirements to receive benefits. If there a waiting period or are your dependents not covered because they have reached a certain age and no longer qualify? If it is determined that you meet the criteria for a claim to be filed, your SPD contains information about where to file, what to file and whom to contact if you have any questions about your plan. "Plans cannot charge any filing fees or costs for filing claims and appeals. When a claim is filed, be sure to keep a copy for your own records." (www.dol.gov)

While waiting for a decision on your claim, please note that all health and disability benefit claims must be decided within a specific time limit, depending on the type of claim filed. "ERISA sets specific periods of time for plans to evaluate your claim and inform you of a decision. The time limits are counted in calendar days, so weekends and holidays are included. These limits do not govern when the benefits must be paid or provided. Plans are required to pay or provide benefits within a reasonable time after the claims is approved." (www.dol.gov.)

Urgent Care Claims must be decided as soon as possible, taking into account the medical needs of the patient, but no later than 72 hours after the plan receives the claim. The plan must tell you within 24 hours if more information is needed and you will have no less than 48 hours to respond. Then the plan must decide the claim within 48 hours after the missing information is supplied or the time to supply it has elapsed. The plan cannot extend the time to make the initial decision without your consent. The plan must give you notice that your claim has been granted or denied before the end of the time allotted for the decision. The plan can notify you orally of the benefit determination so long as a written notification is furnished to you no later than three days after the oral notification.

Pre-Service Claims must be decided within a reasonable period time appropriate to the medical circumstances, but no later than 15 days after the plan has received the claim. The plan may extend the time period up to an additional 15 days, if for reasons beyond the plan's control, the decision cannot be made within the first 15 days. The plan administrator must notify you prior to the expiration of the first 15-say period, explaining the reason for the delay, requesting any additional information, and advising you when the plan expects to make the decision. If more information is requested, you have at least 45 days to supply it. The plan then must decide the claim no later than 15 days after you supply the additional information or after the period of time allowed to supply it ends, whichever comes first. If the plan wants more time, the plan needs your consent. The plan must give you written notice that your claim has been granted or denied before the end of the time allotted for the decision.

A simple flow chart designed to help you navigate through the insurance claim process. Any ?'s call someone.



Post-Service Health Claims must be decided within a reasonable period of time, but not later than 30 days after the plan has received the claim. If, because of reasons beyond the plan's control, more time is needed to review your request, the plan may extend the time period up to an additional 15 days. However, the plan administrator has to let you know before the end of the first 30-day period, explaining the reason for the delay, requesting any additional information needed, and advising you when a final decision is expected. If more information is requested, you have at least 45 days to supply it. The claim then must be decided no later than 15 days after you supply the additional information or the period of time given by the plan to do so ends, whichever comes first. The plan needs you consent if it wants more time after its first extension. The plan must give you notice that your claim has been denied in whole or in part (paying less than 100% of the claim) before the end of the time allotted for the decision.

Disability Claims must be decided within a reasonable period of time, but not later than 45 days after the plan has received the claim. If, because of reasons beyond the plan's control, more time is needed to review your request, the plan can extend the timeframe up to 30 days. The plan must tell you prior to the end of the first 45-day period that additional time is needed, explaining why any unresolved issues and additional information is needed, and when the plan expects to render a final decision. If more information is requested during either extension period, you will have at least 45 days to supply it. The claim then must be decided no later than 30 days after you supply the additional information or the period of time given by the plan to do so ends, whichever comes first. The plan administrator may extend the time period up to another 30 days as long as it notifies you before the first extension expires. For any additional extensions, the plan needs your consent. The plan must give you notice whether your claim has been denied before the end of the time allotted for the decision.

If your claim is denied, the plan administrator must send you a notice, either in writing or electronically, with a detailed explanation of why your claim was denied and a description of the appeal process. In addition, the plan must include the plan rules, guidelines, protocols, or exclusions (such as medical necessity or experimental treatment) used in the decision or provide you with instructions on how you can request a copy from the plan. The notice may also include a specific request for you to provide the plan with additional information in case you wish to appeal your denial. Next month, in part 3 of this series, we will cover appealing a denied claim.

KEVIN SHEIL
Business Agent