HOUSE BILL NO. 555

INTRODUCED BY S. FITZPATRICK

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR NONDUPLICATION OF BENEFITS UNDER INDIVIDUAL, GROUP, OR OTHER HEALTH INSURANCE COVERAGE, INCLUDING GOVERNMENTAL EMPLOYEE HEALTH PLANS; PROVIDING FOR INFORMATION GATHERING FROM INSUREDS AND HEALTH CARE PROVIDERS; PROVIDING FOR REFUNDS OR CREDITS IF HEALTH CARE PROVIDERS RECEIVE DUPLICATE PAYMENTS; AMENDING SECTIONS ~~2-18-704,~~ 20-15-225~~,~~ AND 33-22-101, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. No duplication of benefits -- definitions.** (1) A governmental entity is not responsible under a plan or contract issued under this chapter to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by a member or an insured for which:

(a) payment has been made to a health care provider or to a member, an insured, or other person under first-party medical payments coverage~~, third-party medical payments coverage,~~ or third-party liability coverage; or

(b) medical payments coverage is ~~available under any insurance policy or self-funded or governmental health benefit plan with respect to the injury or medical condition and the limits of the policy or plan~~, AT THE TIME THE INJURY OR MEDICAL CONDITION IS SUSTAINED BY A MEMBER OR AN INSURED, IN EFFECT UNDER ANY PROPERTY OR CASUALTY INSURANCE POLICY OR COVERAGE TO THE EXTENT THE MEDICAL PAYMENTS COVERAGE LIMITS OF THE POLICY OR COVERAGE have not been exhausted.

(2) A governmental entity may request and is entitled to obtain from a member, an insured, another insurer, another health benefit plan, or other person the following information regarding the existence and details of any payments made by or for which coverage is available ~~from another insurer or health benefit plan as described in subsection (1)~~:

(a) whether another insurer or health benefit plan has made any payments described in subsection (1);

(b) the existence and limits of any medical payments coverage available under any insurance policy or

health benefit plan with respect to the injury or medical condition;

(c) the particular services, supplies, medications, or other items for which the other insurer or health benefit plan has paid;

(d) the identity of any health care provider or other persons paid by the other insurer or health benefit plan for each particular service, supply, medication, or other item; and

(e) other information reasonably necessary for the governmental entity to determine coverage under the terms of the governmental entity's plan, policy, certificate of insurance, membership contract, or evidence of coverage.

(3) A governmental entity may demand and receive a refund or a credit from a health care provider for the governmental entity's payment for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by a member or an insured that were also paid for by any first-party medical payments coverage~~, third-party medical payments coverage,~~ or third-party liability coverage.

(4) A governmental entity's coverage or denial of payment or the receipt of a refund or a credit from a health care provider under this section is not subject to application of:

(a) the provisions of 2-18-901 or 2-18-902; or

(b) any condition or prerequisite that the member or the insured must be fully compensated or made whole for the member or the insured's injuries or medical condition under any action or doctrine in law or equity.

(5) A governmental entity may include in any health benefit plan, policy, certificate, membership contract, or evidence of coverage issued under this chapter a provision substantially as follows:

"No Duplication of Benefits: The plan or insurer is not responsible under this plan or contract to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by a member or an insured ~~for which coverage has been accepted or~~ for which payment has been made to a health care provider, a member, an insured, or other person under first-party medical payments coverage~~, third-party medical payments coverage, or third-party liability coverage or for which coverage is available under any insurance policy or health benefit plan with respect to the injury or the medical condition.~~ OR THIRD-PARTY LIABILITY COVERAGE. THE PLAN OR INSURER IS NOT RESPONSIBLE UNDER THIS PLAN OR CONTRACT TO COVER OR PAY FOR ANY SERVICES, SUPPLIES, MEDICATIONS, OR OTHER ITEMS PROVIDED TO TREAT ANY INJURY OR MEDICAL CONDITION SUSTAINED BY A MEMBER OR AN INSURED IF MEDICAL PAYMENTS COVERAGE IS IN EFFECT UNDER ANY PROPERTY OR CASUALTY INSURANCE POLICY OR COVERAGE WITH RESPECT TO THE INJURY OR MEDICAL CONDITION TO THE EXTENT THE MEDICAL PAYMENTS COVERAGE LIMITS OF THE POLICY OR COVERAGE HAVE NOT BEEN EXHAUSTED."

(6) A governmental entity may include in any health benefit plan, policy, or insurance contract administered or issued under this chapter other limitations, exclusions, or reductions of coverage that are designed to prevent duplicate payments for the same services, supplies, medications, or other items under the health benefit plan or insurance coverage or under another insurance policy or coverage.

(7) (a) A governmental entity shall credit the amount of any refund or credit described in subsection (1) toward satisfaction of the member's or the insured's deductible, coinsurance, or copayments applicable under the member's or the insured's plan, policy, certificate of insurance, membership contract, or evidence of coverage for purposes of a claim that was submitted to the governmental entity and incurred during the benefit year applicable to the deductible, coinsurance, or copayments.

(b) Subsection (7)(a) does not require a governmental entity to:

(i) credit a refund or a credit for purposes of a claim if the claim would not be covered or paid under the terms of the member's or the insured's plan, policy, certificate of insurance, membership contract, or evidence of coverage even without application of any deductible, coinsurance, or copayments; or

(ii) pay a health care provider an amount that, taking into account the other insurer's or health benefit plan's payment to the health care provider, is in excess of the amount allowable under the terms of the member's or the insured's plan, policy, certificate of insurance, membership contract, or evidence of coverage.

(8) For the purposes of this section, the following definitions apply:

(a) "Employee" has the meaning provided in 2-18-701 and includes a school teacher and any employee of a governmental entity not otherwise covered by 2-18-701.

(b) "Governmental entity" means the state and its agencies or departments, the Montana university system, a political subdivision of the state, a county, a city, a town, a school district, a school board, the board of regents, or a health care or health insurance issuer that administers, under Title 20 or this chapter, an employee group benefit plan, program, arrangement, interlocal agreement between political subdivisions of the state, or any arrangement, benefit plan, or program in which health care coverage is provided to the governmental entity's officers, elected officials, or employees through a self-funded program, a fully insured program, or an employee benefit plan.

(9) NOTHING CONTAINED IN THIS SECTION PROHIBITS A GOVERNMENTAL ENTITY FROM COORDINATING MEDICAL BENEFITS WITH OTHER HEALTH BENEFIT PLANS OR HEALTH INSURANCE POLICIES.

NEW SECTION. **Section 2. No duplication of benefits.** (1) A health insurance issuer that delivers,

issues for delivery, renews, extends, or modifies a policy, certificate of insurance, membership contract, or evidence of coverage for individual or group health insurance coverage is not responsible to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured for which:

(a) payment has been made to a health care provider, insured, or other person under first-party medical payments coverage~~, third-party medical payments coverage,~~ or third-party liability coverage; or

(b) medical payments coverage is ~~available under any insurance policy or self-funded or governmental health benefit plan with respect to the injury or medical condition and the limits of the policy or plan~~, AT THE TIME THE INJURY OR MEDICAL CONDITION IS SUSTAINED BY A MEMBER OR AN INSURED, IN EFFECT UNDER ANY PROPERTY OR CASUALTY INSURANCE POLICY OR COVERAGE TO THE EXTENT THE MEDICAL PAYMENTS COVERAGE LIMITS OF THE POLICY OR COVERAGE have not been exhausted.

(2) The health insurance issuer may request and is entitled to obtain from an insured, another insurer, a health benefit plan, or other person the following information regarding the existence and details of any payments made by or for which coverage is available ~~from another insurer or health benefit plan as described in subsection (1)~~:

(a) whether another insurer or health benefit plan has made any payments described in subsection (1);

(b) the existence and limits of any medical payments coverage available under any insurance policy or health benefit plan with respect to the injury or medical condition;

(c) the particular services, supplies, medications, or other items for which the other insurer or health benefit plan has paid;

(d) the identity of any health care provider or other persons paid by the other insurer or health benefit plan for each particular service, supply, medication, or other item; and

(e) other information reasonably necessary for the health insurance issuer to determine coverage under the terms of the health insurance issuer's policy, certificate of insurance, membership contract, or evidence of coverage.

(3) A health insurance issuer may demand and receive a refund or a credit from a health care provider for the health insurance issuer's payment for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured that were also paid for by any first-party medical payments coverage~~, third-party medical payments coverage,~~ or third-party liability coverage.

(4) A health insurance issuer's coverage or denial of payment or the receipt of a refund or a credit from

a health care provider under this section is not subject to application of:

(a) the provisions of 2-18-901, 2-18-902, 33-22-1601, 33-22-1602, 33-30-1101, or 33-30-1102; or

(b) any condition or prerequisite that the insured must be fully compensated or made whole for the insured's injuries or medical condition under any action or doctrine in law or equity.

(5) A health insurance issuer may include in any policy, certificate of insurance, membership contract, or evidence of coverage for health insurance coverage a provision substantially as follows:

"No Duplication of Benefits: The insurer is not responsible under this contract to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured ~~for which coverage has been accepted or~~ for which payment has been made to a health care provider, insured, or other person under first-party medical payments coverage~~, third-party medical payments coverage, or third-party liability coverage or for which coverage is available under any insurance policy or health benefit plan with respect to the injury or the medical condition.~~ OR THIRD-PARTY LIABILITY COVERAGE. THE INSURER IS NOT RESPONSIBLE UNDER THIS PLAN OR CONTRACT TO COVER OR PAY FOR ANY SERVICES, SUPPLIES, MEDICATIONS, OR OTHER ITEMS PROVIDED TO TREAT ANY INJURY OR MEDICAL CONDITION SUSTAINED BY A MEMBER OR AN INSURED IF MEDICAL PAYMENTS COVERAGE IS IN EFFECT UNDER ANY PROPERTY OR CASUALTY INSURANCE POLICY OR COVERAGE WITH RESPECT TO THE INJURY OR MEDICAL CONDITION TO THE EXTENT THE MEDICAL PAYMENTS COVERAGE LIMITS OF THE POLICY OR COVERAGE HAVE NOT BEEN EXHAUSTED."

(6) A health insurance issuer may include in any policy, certificate of insurance, membership contract, or evidence of coverage other limitations, exclusions, or reductions of coverage that are designed to prevent duplicate payments for the same services, supplies, medications, or other items under the health insurance coverage or under another insurance policy or coverage.

(7) (a) A health insurance issuer shall credit the amount of any refund or credit described in subsection (1) toward satisfaction of the insured's deductible, coinsurance, or copayments applicable under the insured's policy, certificate of insurance, membership contract, or evidence of coverage for purposes of a claim that was submitted to the health insurance issuer and incurred during the benefit year applicable to the deductible, coinsurance, or copayments.

(b) Subsection (7)(a) does not require a health insurance issuer to:

(i) credit a refund or a credit for purposes of a claim if the claim would not be covered or paid under the terms of the insured's policy, certificate of insurance, membership contract, or evidence of coverage, even without application of any deductible, coinsurance, or copayments; or

(ii) pay a health care provider an amount that, taking into account the other insurer's or health benefit plan's payment to the health care provider, is in excess of the amount allowable under the terms of the insured's policy, certificate of insurance, membership contract, or evidence of coverage.

(8) NOTHING CONTAINED IN THIS SECTION PROHIBITS A HEALTH INSURANCE ISSUER FROM COORDINATING MEDICAL BENEFITS WITH OTHER HEALTH BENEFIT PLANS OR HEALTH INSURANCE POLICIES.

(9) A HEALTH INSURANCE ISSUER, UPON RECEIVING WRITTEN NOTICE FROM ITS INSURED THAT THE INSURED'S INJURIES OR MEDICAL CONDITION WERE CAUSED BY A THIRD PARTY, SHALL INFORM THE INSURED IN WRITING THAT THE INSURED IS NOT REQUIRED TO HAVE THE RESPONSIBLE THIRD PARTY'S PROPERTY OR CASUALTY INSURER PAY FOR THE INSURED'S MEDICAL EXPENSES CAUSED BY THE THIRD PARTY.

NEW SECTION. **Section 3. No duplication of benefits.** (1) The association and any association plan issued, renewed, extended, or modified that provides health insurance coverage is not responsible to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured for which:

(a) payment has been made to a health care provider, insured, or other person under first-party medical payments coverage~~, third-party medical payments coverage,~~ or third-party liability coverage; or

(b) medical payments coverage is ~~available under any insurance policy or self-funded or governmental health benefit plan with respect to the injury or medical condition, and the limits of the policy~~, AT THE TIME THE INJURY OR MEDICAL CONDITION IS SUSTAINED BY A MEMBER OR AN INSURED, IN EFFECT UNDER ANY PROPERTY OR CASUALTY INSURANCE POLICY OR COVERAGE TO THE EXTENT THE MEDICAL PAYMENTS COVERAGE LIMITS OF THE POLICY OR COVERAGE have not been exhausted.

(2) The association or its lead carrier on behalf of the association may request and is entitled to obtain from an insured, another insurer, another health benefit plan, or other person the following information regarding the existence and details of any payments made by or for which coverage is available ~~from another insurer or health benefit plan as described in subsection (1)~~:

(a) whether another insurer or health benefit plan has made any payments described in subsection (1);

(b) the existence and limits of any medical payments coverage available under any insurance policy or health benefit plan with respect to the injury or medical condition;

(c) the particular services, supplies, medications, or other items for which the other insurer or health benefit plan has paid;

(d) the identity of any health care provider or other persons paid by the other insurer or health benefit plan for each particular service, supply, medication, or other item; and

(e) other information reasonably necessary for the association or its lead carrier to determine coverage under the terms of the association plan.

(3) The association or its lead carrier on behalf of the association may demand and receive a refund or a credit from a health care provider for the association's payment for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured that were also paid for by any first-party medical payments coverage~~, third-party medical payments coverage,~~ or third-party liability coverage.

(4) An association plan's coverage or denial of payment or the receipt of a refund or a credit from a health care provider under this section is not subject to application of:

(a) the provisions of 33-22-1601 or 33-22-1602; or

(b) any condition or prerequisite that the insured must be fully compensated or made whole for the insured's injuries or medical condition under any action or doctrine in law or equity.

(5) The association or its lead carrier on behalf of the association may include in any association plan contract a provision substantially as follows:

"No Duplication of Benefits: The association is not responsible under this contract to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured ~~for which coverage has been accepted or~~ for which payment has been made to a health care provider, insured, or other person under first-party medical payments coverage~~, third-party medical payments coverage, or third-party liability coverage or for which coverage is available under any insurance policy or health benefit plan with respect to the injury or the medical condition.~~ OR THIRD-PARTY LIABILITY COVERAGE. THE ASSOCIATION IS NOT RESPONSIBLE UNDER THIS PLAN OR CONTRACT TO COVER OR PAY FOR ANY SERVICES, SUPPLIES, MEDICATIONS, OR OTHER ITEMS PROVIDED TO TREAT ANY INJURY OR MEDICAL CONDITION SUSTAINED BY A MEMBER OR AN INSURED IF MEDICAL PAYMENTS COVERAGE IS IN EFFECT UNDER ANY PROPERTY OR CASUALTY INSURANCE POLICY OR COVERAGE WITH RESPECT TO THE INJURY OR MEDICAL CONDITION TO THE EXTENT THE MEDICAL PAYMENTS COVERAGE LIMITS OF THE POLICY OR COVERAGE HAVE NOT BEEN EXHAUSTED."

(6) The association or its lead carrier on behalf of the association may include in any association plan contract other limitations, exclusions, or restrictions of coverage that are designed to prevent duplicate payments for the same services, supplies, medications, or other items under the health insurance coverage or under another insurance policy or coverage.

(7) (a) The association or its lead carrier on behalf of the association shall credit the amount of any refund or credit described in subsection (1) toward satisfaction of the insured's deductible, coinsurance, or copayments applicable under the association plan for purposes of a claim that was submitted to the association and incurred during the benefit year applicable to the deductible, coinsurance, or copayments.

(b) Subsection (7)(a) does not require the association or its lead carrier on behalf of the association to:

(i) credit a refund or a credit for purposes of a claim if the claim would not be covered or paid under the terms of the plan even without application of any deductible, coinsurance, or copayments; or

(ii) pay a health care provider an amount that, taking into account the other insurer's or health benefit plan's payment to the health care provider, is in excess of the amount allowable under the terms of the plan.

(8) NOTHING CONTAINED IN THIS SECTION PROHIBITS THE ASSOCIATION OR ITS LEAD CARRIER FROM COORDINATING MEDICAL BENEFITS WITH OTHER HEALTH BENEFIT PLANS OR HEALTH INSURANCE POLICIES.

~~**Section 4.** Section 2-18-704, MCA, is amended to read:~~

~~**"2-18-704. Mandatory and optional provisions.** (1) An insurance contract or plan issued under this part must contain provisions that permit:~~

~~(a) the member of a group who retires from active service under the appropriate retirement provisions of a defined benefit plan provided by law or, in the case of the defined contribution plan provided in Title 19, chapter 3, part 21, a member with at least 5 years of service and who is at least age 50 while in covered employment to remain a member of the group until the member becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, as amended, unless the member is a participant in another group plan with substantially the same or greater benefits at an equivalent cost or unless the member is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost;~~

~~(b) the surviving spouse of a member to remain a member of the group as long as the spouse is eligible for retirement benefits accrued by the deceased member as provided by law unless the spouse is eligible for medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible for equivalent insurance coverage as provided in subsection (1)(a);~~

~~(c) the surviving children of a member to remain members of the group as long as they are eligible for retirement benefits accrued by the deceased member as provided by law unless they have equivalent coverage as provided in subsection (1)(a) or are eligible for insurance coverage by virtue of the employment of a surviving~~

~~parent or legal guardian.~~

~~(2) An insurance contract or plan issued under this part must contain the provisions of subsection (1) for remaining a member of the group and also must permit:~~

~~(a) the spouse of a retired member the same rights as a surviving spouse under subsection (1)(b);~~

~~(b) the spouse of a retiring member to convert a group policy as provided in 33-22-508; and~~

~~(c) continued membership in the group by anyone eligible under the provisions of this section, notwithstanding the person's eligibility for medicare under the federal Health Insurance for the Aged Act.~~

~~(3) (a) A state insurance contract or plan must contain provisions that permit a legislator to remain a member of the state's group plan until the legislator becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, as amended, if the legislator:~~

~~(i) terminates service in the legislature and is a vested member of a state retirement system provided by law; and~~

~~(ii) notifies the department of administration in writing within 90 days of the end of the legislator's legislative term.~~

~~(b) A former legislator may not remain a member of the group plan under the provisions of subsection (3)(a) if the person:~~

~~(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost; or~~

~~(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.~~

~~(c) A legislator who remains a member of the group under the provisions of subsection (3)(a) and subsequently terminates membership may not rejoin the group plan unless the person again serves as a legislator.~~

~~(4) (a) A state insurance contract or plan must contain provisions that permit continued membership in the state's group plan by a member of the judges' retirement system who leaves judicial office but continues to be an inactive vested member of the judges' retirement system as provided by 19-5-301. The judge shall notify the department of administration in writing within 90 days of the end of the judge's judicial service of the judge's choice to continue membership in the group plan.~~

~~(b) A former judge may not remain a member of the group plan under the provisions of this subsection (4) if the person:~~

~~(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost;~~

~~(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost; or~~

~~(iii) becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, as amended.~~

~~(c) A judge who remains a member of the group under the provisions of this subsection (4) and subsequently terminates membership may not rejoin the group plan unless the person again serves in a position covered by the state's group plan.~~

~~(5) A person electing to remain a member of the group under subsection (1), (2), (3), or (4) shall pay the full premium for coverage and for that of the person's covered dependents.~~

~~(6) An insurance contract or plan issued under this part that provides for the dispensing of prescription drugs by an out-of-state mail service pharmacy, as defined in 37-7-702:~~

~~(a) must permit any member of a group to obtain prescription drugs from a pharmacy located in Montana that is willing to match the price charged to the group or plan and to meet all terms and conditions, including the same professional requirements that are met by the mail service pharmacy for a drug, without financial penalty to the member; and~~

~~(b) may only be with an out-of-state mail service pharmacy that is registered with the board under Title 37, chapter 7, part 7, and that is registered in this state as a foreign corporation.~~

~~(7) An insurance contract or plan issued under this part must include coverage for treatment of inborn errors of metabolism, as provided for in 33-22-131.~~

~~(8) An insurance contract or plan issued under this part must include substantially equivalent or greater coverage for outpatient self-management training and education for the treatment of diabetes and certain diabetic equipment and supplies as provided in 33-22-129.~~

~~(9) (a) An insurance contract or plan issued under this part that provides coverage for an individual in a member's family must provide coverage for well-child care for children from the moment of birth through 7 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the contract or plan.~~

~~(b) Coverage for well-child care under subsection (9)(a) must include:~~

~~(i) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and~~

~~(ii) routine immunizations according to the schedule for immunization recommended by the immunization practice advisory committee of the U.S. department of health and human services.~~

~~(c) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit as provided for in this subsection (9).~~

~~(d) For purposes of this subsection (9):~~

~~(i) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics; and~~

~~(ii) "well-child care" means the services described in subsection (9)(b) and delivered by a physician or a health care professional supervised by a physician.~~

~~(10) (a) Except as provided in subsection (10)(b), upon renewal, an insurance contract or plan issued under this part under which coverage of a dependent terminates at a specified age must, as provided in 33-22-152, continue to provide coverage for any unmarried dependent, as defined in 33-22-140(5)(b), until the dependent reaches 25 years of age or marries, whichever occurs first. For insurance contracts or plans issued under this part, the premium charged for the additional coverage of a dependent, as defined in 33-22-140(5)(b), may be required to be paid by the insured and not by the employer.~~

~~(b) An insurance contract or plan issued under this part for the state employee group insurance program and the university system group insurance program is not subject to subsection (10)(a).~~

~~(11) Prior to issuance of an insurance contract or plan under this part, written informational materials describing the contract's or plan's cancer screening coverages must be provided to a prospective group or plan member.~~

~~(12) An insurance contract or plan issued under this part may contain the provisions of [section 1].~~"

Section 4. Section 20-15-225, MCA, is amended to read:

"20-15-225. Powers and duties of trustees. (1) The trustees of a community college district shall, subject to supervision by the board of regents:

(a) have general control and supervision of the community college;

(b) adopt rules, not inconsistent with the constitution and the laws of the state, for the government and administration of the community college;

(c) grant certificates and degrees to the graduates of the community college;

(d) keep a record of their proceedings;

(e) when not otherwise provided by law, have control of all books, records, buildings, grounds, and other property of the community college;

(f) receive from the state board of land commissioners; other boards, agencies, or persons; or the government of the United States all funds, income, and other property the community college may be entitled to receive or accept and use and appropriate the property for the specific purpose of the entitlement, grant, or donation;

(g) have general control of all receipts and disbursements of the community college;

(h) appoint and dismiss a president and faculty for the community college; appoint and dismiss any other necessary officers, agents, and employees; fix their compensation; and set the terms and conditions of their employment;

(i) administer the tuition provision and otherwise govern the students of the community college district in accordance with the provisions of this chapter;

(j) call and conduct the elections of the district in accordance with the school election chapter of this title;

(k) participate in the teachers' retirement system of the state of Montana in accordance with the provisions of the teachers' retirement system chapter of this title;

(l) establish employee benefits, other than retirement benefits, and fix their limits in accordance with 2-18-701 through 2-18-704 and [section 1]; and

(m) participate in district boundary change actions in accordance with the provisions of the district organization chapter of this title.

(2) The trustees of a community college district shall hold in trust all real and personal property of the district for the benefit of the college and students.

(3) The trustees of a community college district may enter into agreements with the western interstate commission for higher education, or similar intrastate, interstate, or international agreements, for the benefit of the district and students."

Section 5. Section 33-22-101, MCA, is amended to read:

"33-22-101. Exceptions to scope. (1) Subject to subsection (2), parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136, 33-22-140, 33-22-141, 33-22-142, 33-22-243, and 33-22-304, and part 19 of this chapter do not apply to or affect:

(a) any policy of liability or workers' compensation insurance with or without supplementary expense

coverage;

(b) any group or blanket policy;

(c) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance that:

(i) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(ii) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled as defined by the contract or supplemental contract;

(d) reinsurance.

(2) Sections 33-22-137, 33-22-150 through 33-22-152, [section 2], and 33-22-301 apply to group or blanket policies."

NEW SECTION. **Section 6. Codification instruction.** (1) [Section 1] is intended to be codified as an integral part of Title 2, chapter 18, part 7, and the provisions of Title 2, chapter 18, part 7, apply to [section 1].

(2) [Section 2] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 2].

(3) [Section 3] is intended to be codified as an integral part of Title 33, chapter 22, part 15, and the provisions of Title 33, chapter 22, part 15, apply to [section 3].

NEW SECTION. **Section 7. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 8. Effective date -- applicability.** [This act] is effective on passage and approval and applies to all benefit claims arising on or after [the effective date of this act].

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