(4) "Multiple risk factors" means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall:

(1) provide coverage for an annual routine chlamydia screening test ~~AND ANNUAL ROUTINE HUMAN PAPILLOMAVIRUS SCREENING TEST~~ for:

~~[~~(1)~~]~~ (I) women who are:

~~[~~(i)~~]~~ 1. under the age of 20 years if they are sexually active; and

~~[~~(ii)~~]~~ 2. at least 20 years old if they have multiple risk factors; and

~~[~~(2)~~]~~ (II) men who have multiple risk factors; AND

(2) ~~PROVIDE EDUCATIONAL MATERIAL TO ENROLLEES, MEMBERS, OR SUBSCRIBERS ON THE HEALTH RISKS ASSOCIATED WITH THE HUMAN PAPILLOMAVIRUS AND THE AVAILABILITY OF COVERAGE FOR THE HUMAN PAPILLOMAVIRUS SCREENING TEST~~ PROVIDE COVERAGE FOR A HUMAN PAPILLOMAVIRUS SCREENING AT THE TESTING INTERVALS OUTLINED IN THE RECOMMENDATIONS FOR CERVICAL CYTOLOGY SCREENING DEVELOPED BY THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS.

(d) (1) Subject to paragraph (2) of this subsection, the coverage required under this section may be subject to a co–payment or coinsurance requirement or deductible that an entity subject to this section imposes for similar coverages under the same policy or contract.

(2) The co–payment or coinsurance requirement or deductible imposed under paragraph (1) of this subsection may not be greater than the co–payment or coinsurance requirement or deductible imposed by the entity for similar coverages.

(e) Nothing in this section may be construed to prohibit an entity subject to this section from providing coverages that are greater than or more favorable to an insured or enrollee than the coverage required under this section.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2005. Any policy or health benefit plan in effect before October 1, 2005, shall comply with the provisions of this Act no later than October 1, 2006.