

Article - Insurance

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§15–829.

(a) (1) In this section the following words have the meanings indicated.

(2) “Chlamydia screening test” means any laboratory test that:

(i) specifically detects for infection by one or more agents of chlamydia trachomatis; and

(ii) is approved for this purpose by the federal Food and Drug Administration.

(3) “Human papillomavirus screening test” means any laboratory test that:

(i) specifically detects for infection by one or more agents of the human papillomavirus; and

(ii) is approved for this purpose by the federal Food and Drug Administration.

(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 for:

(i) women who are:

1. under the age of 20 years if they are sexually active; and

2. at least 20 years old if they have multiple risk factors; and

(ii) men who have multiple risk factors; and

(2) 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 copayment or coinsurance requirement or deductible that an entity subject to this section imposes for similar coverages under the same policy or contract.

(2) The copayment or coinsurance requirement or deductible imposed under paragraph (1) of this subsection may not be greater than the copayment 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.

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