Wisconsin Stat. § 632.895 (16)

(16) Hearing aids, cochlear implants, and related treatment for infants and children.

(a) In this subsection:

1. "Cochlear implant" includes any implantable instrument or device that is designed to enhance hearing.

2. "Hearing aid" means any externally wearable instrument or device designed for or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except batteries and cords.

3. "Physician" has the meaning given in s. 448.01 (5).

4. "Self-insured health plan" means a self-insured health plan of the state or a county, city, village, town, or school district.

5. "Treatment" means services, diagnoses, procedures, surgery, and therapy provided by a health care professional.

(b)

1. Except as provided in par. (c), every disability insurance policy and every self-insured health plan shall provide the following coverages:

a. Coverage of the cost of hearing aids and cochlear implants that are prescribed by a physician, or by an audiologist licensed under subch. II of ch. 459, in accordance with accepted professional medical or audiological standards, for a child covered under the policy or plan who is under 18 years of age and who is certified as deaf or hearing impaired by a physician or by an audiologist licensed under subch. II of ch. 459.

b. Coverage of the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices, for a child specified in subd. 1. a.

2. Coverage of the cost of hearing aids under this subsection is not required to exceed the cost of one hearing aid per ear per child more often than once every 3 years.

3. The coverage required under this subsection may be subject to any cost-sharing provisions, limitations, or exclusions, other than a preexisting condition exclusion, that apply generally under the disability insurance policy or self-insured health plan.

(c) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A disability insurance policy, or a self-insured health plan of the state or a county, city, town, village, or school district, that provides only limited-scope dental or vision benefits.

3. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

4. A long-term care insurance policy.

5. A medicare replacement policy or a medicare supplement policy.

5m. An individual health benefit plan that is not renewable and that has a specified termination date that, including any extensions that the policyholder may elect without the insurer's consent, is less than 12 months after the original effective date.