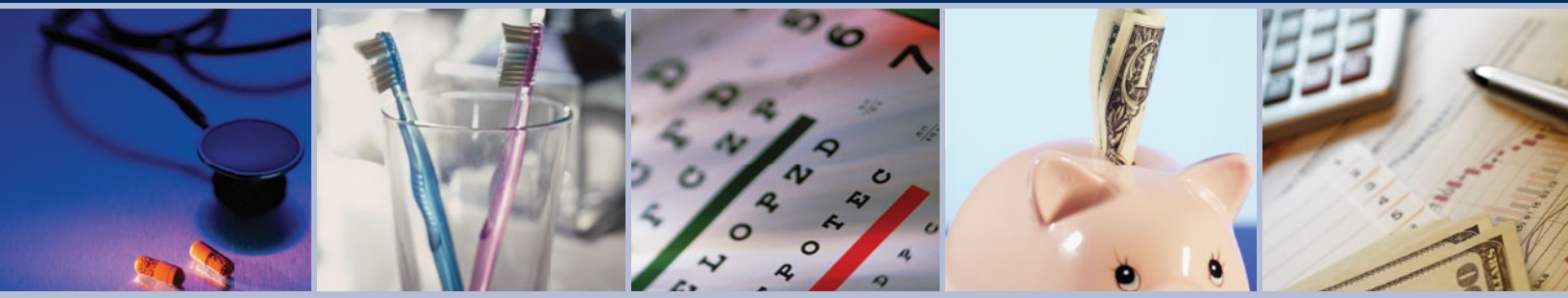
Hillenbrand, Inc.

My Benefits

Choices for Your Health and Financial Well-Being



2012 Benefits Decision Guide

Choose Well, Live Well

Our vision for a healthy future

At Hillenbrand, Inc. we are committed to helping you achieve your highest level of well-being. When you're healthy, you're able to live a happier, more productive, and more fulfilling life. You're also able to more fully contribute to – and benefit from – our business success.

As part of our vision to promote the highest levels of health and preventive care, Hillenbrand, Inc. offers you and your family a comprehensive benefits program that gives you the flexibility to tailor your benefits to your specific needs. Each year, we review our program to ensure that it is competitive in terms of both its cost and the quality of its options, and to give you the opportunity to make changes.

As a new employee, you have the opportunity to make your health care benefit elections. If you do not access the enrollment system and elect coverage within 31 days of your eligibility date, you will automatically receive default employee-only coverage in the Standard Medical Plan. Coverage for other benefits such as dental, vision, Flexible Spending Accounts, and voluntary insurance will be waived. Therefore, it is important that you take action today to elect the coverage that is right for you and your family.

Be an informed health care consumer

You are encouraged to be an active consumer and review your benefits' specific options and costs. Be sure to review the plan details carefully as there may be valuable features you do not know about and varying out-of-pocket expenses. Please see page 3 for an overview of online tools and resources that can help you make more informed benefit decisions.

For more information or answers to your questions, visit Hillenbrand, Inc. Benefits Online at www.hillenbrandinc.mercerhrs.com or call 1-866-470-0846.

Be sure to enroll in your 2012 benefits today.

For bargaining employees only.

What's inside?

Use your Personalized Enrollment Worksheet

Your enclosed Personalized Enrollment Worksheet (PEW) is a valuable tool you can use to review your personal information, coverage options, and per-paycheck costs for your 2012 benefit options. Simply check off your selected benefit options on your PEW as you make your decisions.

Log on to Hillenbrand, Inc. Benefits Online at www.hillenbrandinc.mercerhrs.com to make your benefit elections or call 1-866-470-0846 with questions.

Take control of your health care spending

The importance of prevention

First and foremost, we want to help you stay well. Taking care of your health and obtaining regular check-ups are the best ways to prevent the development of illness and the use of expensive health care. Approximately half of all chronic diseases are linked to preventable conditions, including smoking, obesity, and physical inactivity.

Being a smart health care consumer

Even the best efforts to stay healthy can't always prevent the need for non-routine care. That's when it's comforting to know you have the most appropriate insurance plan in place. To help you select the plan that offers the right coverage with the most financial advantages, we encourage you to think about your health benefits in a new way.

Traditionally, people purchased insurance to protect themselves from the actual cost of their care. With this approach, there was little motivation to keep usage or costs down. Consumers didn't know what was being spent on their care, and at the end of the year, they may have paid more in insurance costs than they would have paid for the care itself.

Today, many health plans are designed to help you control your overall out-of-pocket expenses by rewarding you for choosing your care wisely. Things like researching different care options, comparing providers, and requesting generic prescription drugs can make a big difference in your health care costs.

Choosing the right plan for you

Be sure to carefully consider your needs and preferences when selecting the best plan for you and your family. This guide will provide detailed information about each option available to you. Further information can be found by logging on to Hillenbrand, Inc. Benefits Online at www.hillenbrandinc.mercerhrs.com.

A partnership for better health and financial well-being

Managing health care costs is a shared responsibility. Our role is to provide the plans and resources you need to take care of your health and make smart health care decisions. Your role is to actively participate in the decision-making process and make healthy choices. The best place to start is by logging on to Hillenbrand, Inc. Benefits Online at www.hillenbrandinc.mercerhrs.com. From there, you can learn about your benefit options, make your benefit elections, and manage your benefits – all in one convenient place. You can:

- ☑ View your current benefit plan elections and coverage levels
- ☑ Review and update your personal, dependent, and beneficiary data
- ☑ Process life event changes during the year
- ☑ Link to carriers' websites for detailed contact information
- ☑ Obtain detailed benefit information

Make the most of your benefits

To help you make informed benefit decisions, Hillenbrand, Inc. Benefits Online also offers the following online tools and calculators:

Health Care Summary Plan Description (SPD)
Provides online access to your benefits information. This interactive tool allows you to find information in a variety of ways.

Plan comparison tool
Provides a side-by-side comparison of up to three medical plans to help you determine which option is best for you, and allows you to take a closer look at the specific services covered in the dental and vision plans.

Flexible Spending Account calculators
Help you determine your coverage needs so you can take advantage of these important benefits.

Get personal assistance by phone

Service Representatives are available by phone to help you compare medical plans and answer your questions. Just call 1-866-470-0846, Monday through Friday, between 9:00 a.m. and 6:00 p.m. Eastern Time.

Your benefits at a glance

EMPLOYEES MAY CHOOSE TO ELECT OR UPDATE COVERAGE	COVERAGE IS AUTOMATICALLY PROVIDED BY HILLENBRAND, INC.
Medical Plan	Basic Life Insurance
Dental Plan	Basic AD&D
Vision Care Plan	Short-Term Disability
Health Care Flexible Spending Account (FSA)*	Employee Assistance Program (EAP)
Dependent Care Flexible Spending Account (FSA)*	
Voluntary Accidental Death and Dismemberment Insurance (AD&D)	

* Please note that you must re-enroll for these benefits each year.

Changing coverage during the year

For those benefits listed in the left-hand column in the table above, you can make changes during the year only if you experience a qualified life event, including a change in:

Marital status – Marriage, divorce, legal separation, or annulment

Number of dependents – Birth, adoption, or placement for adoption

Employment status – Beginning or ending employment or change in work schedule by you, your spouse, or your dependent if it affects eligibility

Dependent status – Gain or loss of eligibility because of age

Residence or worksite – Change for you, your spouse, or dependent – only if the plan is not available in the new location

Death – Death of a spouse or covered dependent

See your Summary Plan Description for a complete list of qualified life events.

Remember! When you experience a qualified life event, you have 60 days from the date of the event to access Hillenbrand, Inc. Benefits Online or call the Hillenbrand, Inc. Benefits Center and change your benefit elections (changes must be related to the life event). If you do not make changes within 60 days, you will have to wait until the next Open Enrollment period to make benefit elections related to that life event.

Eligibility for benefits coverage

You have the option of electing from the following coverage levels:

- Employee only
- Employee + child(ren)
- Employee + spouse
- Employee + family

You may cover your eligible dependents, including but not limited to:

- Your spouse
- Your dependent child(ren) under age 26
- Your unmarried child(ren) over age 26 who, because of a mental or physical disability, remains wholly dependent

Dependent children include: natural children, stepchildren, legally adopted children, children for whom you have been appointed legal guardian, and children for whom you are required by court order to provide health coverage.

If you are enrolling a dependent, you are required to provide proof of dependent eligibility. Proof of eligibility documentation must be faxed to the Hillenbrand, Inc. Benefits Center at 1-888-891-3630, or mailed to the address below within 31 days of your enrollment date.

Hillenbrand, Inc. Benefits Center
P.O. Box 9735
Providence, Rhode Island 02940

Acceptable forms of documentation for dependent eligibility are listed below.

DEPENDENT TYPE	REQUIRED DOCUMENTATION
Spouse	■ Copy of marriage certificate, **and** ■ If married for over two years, a copy of your most recent tax return (front page)
Children under age 26	One of the following: ■ Copy of birth certificate ■ Copy of hospital birth certificate ■ Copy of adoption agreement ■ Copy of court custody or guardianship documents ■ Copy of the portion of the Divorce Decree naming the custodial parent ■ Qualified Medical Child Support Order (QMCSO)
Children over age 26 who are fully handicapped	■ Copy of the notice of disability from Social Security Administration or physician's statement of disability

For more specific information on dependents eligible for coverage under your benefits, please refer to the Health Care Summary Plan Description available on www.hillenbrandinc.mercerhrs.com.

Please note: If your spouse works for Hillenbrand, Inc., or its subsidiaries, you may not be covered both as an employee of the company and as a dependent of another employee. And if you have children, only one of you may elect coverage for them. If you want to be listed as a dependent on your spouse's plan, you must first waive coverage under your own plan.*

*Applies only to medical, dental, vision, and voluntary AD&D coverage.

! Make sure your dependent information is complete

All of your dependents two years of age or older ***must*** have a Social Security number on file. Please log on to www.hillenbrandinc.mercerhrs.com or call the Hillenbrand, Inc. Benefits Center to confirm the dependent information on file and make updates, if necessary.

When coverage begins

For new employees in 2012, your coverage begins as stated in your respective Collective Bargaining Agreement (CBA).

When coverage ends

Benefits coverage for you and any enrolled dependents will end the day your employment is terminated. Coverage for dependents will also end when they no longer meet the definition of a dependent under the individual plans.

Covered participants and eligible dependents in the medical, dental, vision plans, Employee Assistance Program (if applicable), and Flexible Spending Accounts may elect to continue coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) after the date of termination. If you or your covered dependents lose coverage, a COBRA election form will be sent out by our COBRA administrator, which will give you the option of continuing your group health coverage for a designated period, as required by COBRA law.

Basic life insurance and basic AD&D coverage can be converted to a private policy within 31 days of termination.

Medical plan options

Hillenbrand, Inc. offers a variety of medical plans so that you can choose the one that is right for you and your family.

Higher per-paycheck cost/Lower out-of-pocket cost

Premier Plan

Enhanced Plan

Standard Plan

Lower per-paycheck cost/Higher out-of-pocket cost

Health Design Plus is the administrator for medical claims, COBRA, and Flexible Spending Accounts. EnvisionRx is the retail pharmacy manager and OrchardRx is the mail-order pharmacy manager.

All of the plan options are based on a preferred provider organization (PPO) using the Anthem network, which means you can take advantage of the large Anthem network of medical providers who offer their services at negotiated prices. Although the plans offer both in- and out-of-network coverage, if you use an in-network provider, the plan pays a greater percentage of the cost and you pay a lower deductible than if you use an out-of-network provider.

Comparing your options

Each plan offers a different combination of upfront premium costs (which come out of your paycheck) and out-of-pocket costs (which you pay when you receive health care). When comparing your options, consider which combination is most suitable for your situation and needs.

To select the plan that is best for you, you should estimate the services you expect to use in the coming year and compare them with the coverage and cost of each plan. Using the online plan comparison tool at www.hillenbrandinc.mercerhrs.com can help you do this most efficiently. More detailed information on each option can also be found in the plan comparison chart on the following pages. Please refer to the enclosed Personalized Enrollment Worksheet (PEW) for rate information.

Understanding the total cost of your insurance

You know how much you pay for your health insurance, but do you know how much Hillenbrand, Inc. pays? Starting in 2012, the new health care reform law requires employers to calculate and report the total cost of employer-sponsored health insurance coverage on employees' Form W-2s. This information will help you understand the overall picture of health insurance costs. On average, employers nationwide pay 70% of the annual premium costs and employees pay 30%. When you see your W-2 statement for 2012, you'll notice that Hillenbrand, Inc's. contribution is **more generous than the national average**.*

Get an instant tax break

Be assured that the W-2 reporting does not change the tax status of your health care benefits. Health care benefits continue to be a tax-free benefit. The new reporting requirement is simply for information purposes. Your paycheck deductions for medical, dental, and vision coverage and any reimbursement accounts are automatically taken out on a before-tax basis, lowering your taxable pay and the amount of income tax you pay. All other paycheck deductions for benefits are made on an after-tax basis.

* Source: The Kaiser Family Foundation/Health Research & Educational Trust 2011 Annual Employer Health Benefits Survey.

Medical plan comparison chart

Use the chart below to compare details among medical plan options. Think about the services you use most frequently and try to anticipate any specific care you or your family members may need in 2012.

Preventive care procedures are covered at 100% under all medical plans with no deductible, provided you stay in-network. You can find a complete listing of covered services, as well as information on who should receive these services and how often, by clicking on the "More Benefits Information" link on Hillenbrand, Inc. Benefits Online.

You can find a detailed description of these benefits in the Summary Plan Description (SPD), available by contacting the Hillenbrand, Inc. Benefits Center at 1-866-470-0846 or logging on to Hillenbrand, Inc. Benefits Online and clicking the interactive tool "Health Care Summary Plan Description."

MEDICAL PLAN COMPARISON			
Description	Standard Plan	Enhanced Plan	Premier Plan
Annual deductible In-network	$500 for employee $1,000 for employee + family	$250 for employee $500 for employee + family	None
Out-of-network	$1,000 for employee $2,000 for employee + family	$500 for employee $1,000 for employee + family	$500 for employee $1,000 for employee + family
Annual out-of-pocket maximum (includes annual deductible) In-network	$2,000 for employee $3,500 for employee + family	$1,500 for employee $2,750 for employee + family	$1,000 for employee $2,000 for employee + family
Out-of-network	$3,000 for employee $6,000 for employee + family	$2,500 for employee $5,000 for employee + family	$2,000 for employee $4,000 for employee + family

MEDICAL PLAN COMPARISON (CONT.)

Description	Standard Plan	Enhanced Plan	Premier Plan	All plans
	In-network	In-network	In-network	Out-of-network
Family office visits Office visits Office surgeries Allergy testing and treatment (includes serum and injections)	$20 copay per visit	$15 copay per visit	$15 copay per visit	Plan pays 60%*
Specialist office visits	$35 copay per visit	$30 copay per visit	$30 copay per visit	Plan pays 60%*
Well-baby care (up to age 24 months) Routine physicals Immunizations Routine lab work	Plan pays 100% as dictated by the Preventive Guidelines**	Plan pays 100% as dictated by the Preventive Guidelines**	Plan pays 100% as dictated by the Preventive Guidelines**	Not covered
Well-child care (ages 24 months to 19 years) Routine physicals Immunizations Routine lab work	Plan pays 100% as dictated by the Preventive Guidelines**	Plan pays 100% as dictated by the Preventive Guidelines**	Plan pays 100% as dictated by the Preventive Guidelines**	Not covered
Adult wellness (ages 19+) Routine physicals Pap smear Mammograms Colonoscopy Digital rectal exam Prostate-specific antigen (PSA) test Immunizations Routine lab work Hearing tests	Plan pays 100% as dictated by the Preventive Guidelines**	Plan pays 100% as dictated by the Preventive Guidelines**	Plan pays 100% as dictated by the Preventive Guidelines**	Not covered

MEDICAL PLAN COMPARISON (CONT.)

Description	Standard Plan	Enhanced Plan	Premier Plan	All plans
	In-network	In-network	In-network	Out-of-network
In-patient hospital facility services	$500 copay per admission, per unrelated diagnosis (does not apply to out-of-pocket maximum), then plan pays 100% Semi-private room limited to semi-private negotiated rate; private room limited to semi-private negotiated rate; special care unit (SCU) limited to SCU negotiated rate; includes freestanding birthing centers that meet all state health planning requirements			Plan pays 60%*
In-patient hospital professional services Includes surgeon, radiologist, pathologist, and anesthesiologist	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*
Out-patient services	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*
Chiropractic care Up to 12 visits per calendar year (combined in- and out-of-network)	$35 copay per visit	$30 copay per visit	$30 copay per visit	Plan pays 60%*
Emergency care (if deemed an emergency) Facility services	$100 copay (waived if admitted), then plan pays 70%	$100 copay (waived if admitted), then plan pays 80%	$100 copay (waived if admitted), then plan pays 90%	$100 copay (waived if admitted), then plan pays same as applicable in-network benefit*
Physician services	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays same as applicable in-network benefit*
Urgent care	$50 copay	$50 copay	$50 copay	Plan pays 60%*
Ambulance services Includes air and ground, if medically necessary	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays same as applicable in-network benefit*
Independent lab services	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*
Skilled nursing facility Up to 52 visits per calendar year (combined in- and out-of-network)	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*

MEDICAL PLAN COMPARISON (CONT.)

Description	Standard Plan	Enhanced Plan	Premier Plan	All plans
	In-network	In-network	In-network	Out-of-network
Home care services Up to 100 visits per calendar year (combined in- and out-of-network)	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*
Hospice services Up to 180 days lifetime benefit	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*
Temporomandibular joint (TMJ) treatment Up to $1,500 per person (combined in- and out-of-network)	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*
Maternity services	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*
Infertility services For diagnosis of infertility only; infertility treatment is not covered	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*
Medical supplies, equipment, and appliances	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*
Mental Health In-patient care	$500 flat copay per admission per unrelated diagnosis, then plan pays 70% for all other services	$500 flat copay per admission per unrelated diagnosis, then plan pays 80% for all other services	$500 flat copay per admission per unrelated diagnosis, then plan pays 90% for all other services	Plan pays 60%*
Mental Health Office visits	$20 copay (primary care physician) or $35 copay (any other provider)	$15 copay (primary care physician) or $30 copay (any other provider)	$15 copay (primary care physician) or $30 copay (any other provider)	Plan pays 60%*
Mental Health Out-patient services	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*
Attention Deficit Disorder (ADD) For diagnosis only; treatment is not covered, except for medication checks	$20 copay (primary care physician) or $35 copay (any other provider) per office visit, then plan pays 70% for all other services	$15 copay (primary care physician) or $30 copay (any other provider) per office visit, then plan pays 80% for all other services	$15 copay (primary care physician) or $30 copay (any other provider) per office visit, then plan pays 90% for all other services	Plan pays 60%*

MEDICAL PLAN COMPARISON (CONT.)				
Description	Standard Plan	Enhanced Plan	Premier Plan	All plans
	In-network	In-network	In-network	Out-of-network
Substance Abuse In-patient programs	$500 copay per admission per unrelated diagnosis, then plan pays 70% for all other services	$500 copay per admission per unrelated diagnosis, then plan pays 80% for all other services	$500 copay per admission per unrelated diagnosis, then plan pays 90% for all other services	Plan pays 60%*
Substance Abuse Office visits	$20 copay (primary care physician) or $35 copay (any other provider)	$15 copay (primary care physician) or $30 copay (any other provider)	$15 copay (primary care physician) or $30 copay (any other provider)	Plan pays 60%*
Substance Abuse Out-patient services or programs	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*
Human organ and tissue transplants Up to $10,000 for donor expenses incurred during the 30 days before and 120 days after the transplant				
In-patient services	$500 flat copay per admission per unrelated diagnosis, then plan pays 100%	$500 flat copay per admission per unrelated diagnosis, then plan pays 100%	$500 flat copay per admission per unrelated diagnosis, then plan pays 100%	Plan pays 60%*
Out-patient and physician facility services	Plan pays 70%	Plan pays 80%	Plan pays 90%	Plan pays 60%*

* Up to the maximum allowable amount for each service.
** Preventive Care Services are updated annually and may change throughout the year.

Some helpful definitions

Coinsurance – The percentage you pay once the deductible is met in a PPO plan.

Copay – The specified amount you pay out of pocket for office visits and prescription drugs – the health carrier pays the remaining charges.

Deductible – The expenses you must pay each calendar year before the plan begins to pay benefits. Please note that there may be different annual deductibles for individual and family coverage. Preventive care is covered at 100% under all medical options with no deductible.

Network – A group of providers who contract with a health care carrier to provide services to its members at negotiated rates.

Out-of-pocket maximum – The annual cap on the total dollar amount you must pay, not including medical or prescription copays.

Learn more

Please refer to the Health Care Summary Plan Description, available on Hillenbrand, Inc. Benefits Online, for full disclosure of what is covered under each benefit (including exclusions and limitations), as well as any additional benefits that are not included in this guide.

Prescription drug benefits

When you elect a medical option, your prescription drug benefits are automatically included in the cost. Regardless of whether you elect the Standard, Enhanced, or Premier Plan, you'll receive the same prescription drug coverage.

EnvisionRx will continue to provide prescription drug coverage for all plans in 2012 when you use participating retail pharmacies and/or the mail-order program. If you use a retail pharmacy that does not participate in the EnvisionRx network, you will not receive coverage and will be responsible for paying the full cost of the prescription.

Prescription drug coverage at a glance

The plan uses a formulary approach to prescription drug coverage. A formulary is a list of preferred brand-name drugs that are selected based on their quality, safety, and reasonable costs. You pay less for brand-name drugs on the formulary than for brand-name drugs that are not on the formulary.

This chart shows the benefits you will receive under your prescription drug coverage. If you must purchase a formulary brand-name or nonformulary brand-name drug because a generic is not available, the applicable copay or coinsurance for the brand-name drug (subject to the maximum) will apply.

PRESCRIPTION DRUG COVERAGE	
	Standard, Enhanced, Premier Plans (in-network pharmacy)
Retail Pharmacy (up to a 30-day supply)	
Generic drug	You pay a $5 copay
Formulary brand drug	You pay a $30 copay
Nonformulary brand drug	You pay a $50 copay
OrchardRx Mail-Order Service (up to a 90-day supply)	
Generic drug	You pay a $10 copay
Formulary brand drug	You pay a $60 copay
Nonformulary brand drug	You pay a $100 copay

You can find a complete prescription drug formulary list by logging on to Health Design Plus, or by contacting Health Design Plus directly at 1-877-891-2686.

Tobacco-Free Program

Prescription medications, over-the-counter treatments, and hypnosis, when used as a means of being tobacco free, are covered benefits. The combination of these treatments have a maximum combined benefit limit of $1,000 per participant per lifetime.

Dental benefits

Hillenbrand Inc.'s dental plan, administered by MetLife, is a dental preferred provider organization (PPO) that offers a nationwide network of dentists. You can receive care from any licensed dentist who participates in the network. You can search for a dentist in the MetLife Preferred Dentist Program by logging on to Hillenbrand, Inc. Benefits Online and linking to MetLife.

DENTAL BENEFITS (IN-NETWORK)		
Deductible	$50 for employee only $150 for employee + family	
Annual benefit maximum	$1,500 per person	
Orthodontia lifetime maximum	$1,500 per person	
Covered benefit	**You pay**	**Plan pays**
Preventive services (routine office visits, X-rays, and cleaning)	Not subject to deductible	100%
Basic services*	20% after deductible	80%
Major services*	50% after deductible	50%
Orthodontia (for children under the age of 19)	50% after deductible	50%

* See your Health Care Summary Plan Description, available through Hillenbrand, Inc. Benefits Online, for a description of basic services and major services.

Vision benefits

The Vision Care Plan, offered through EyeMed, offers a simple way to save on vision care expenses, including exams, lenses, frames, contact lenses, and vision corrective procedures. For additional savings opportunities, please review the Health Care Summary Plan Description for more details or access the EyeMed brochure, both available through Hillenbrand, Inc. Benefits Online.

BENEFIT	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Frequency		
Exams	Once every 12 months	
Frames	Once every 24 months or contact lenses	
Lenses	Once every 12 months	
Exam (with dilation as necessary)	You pay a $10 copay	Up to $35 reimbursement
Contact lens fit and follow-up		
Standard	You pay up to $55	Not covered
Premium	10% off retail price	Not covered
Frames (any frame available at provider location)	$125 allowance, plus 20% off any balance over the allowance	Up to $50 reimbursement
Standard plastic lenses		
Single vision	You pay a $20 copay	Up to $25 reimbursement
Bifocals	You pay a $20 copay	Up to $40 reimbursement
Trifocals	You pay a $20 copay	Up to $55 reimbursement
Premium progressive	$85 copay; $120 allowance, plus 20% off any balance over the allowance	Up to $40 reimbursement
Lens options (the price of the option will be added to the base price of your lens)		
UV coating	You pay $15	Not covered
Tint (solid and gradient)	You pay $15	Not covered
Standard scratch-resistance	You pay $15	Not covered
Standard polycarbonate	You pay $40	Not covered
Standard progressives (add on to bifocal)	You pay $85	Up to $40 reimbursement
Standard anti-reflective	You pay $45	Not covered
Other add-ons and services	20% discount	Not covered
Contact lenses – in lieu of standard plastic lenses (allowance covers materials only)		
Conventional	$125 allowance, plus 15% discount off any balance over $125	Up to $100 reimbursement
Disposables	$125 allowance	Up to $100 reimbursement
Medically necessary	You pay $0	Up to $200 reimbursement
Laser vision correction (Lasik or PRK from U.S. Laser Network)	15% off retail price or 5% off promotional price	Not covered

Enhanced Vision Network

For further details, visit www.eyemedvisioncare.com or call 1-866-723-0513.

Other insurance benefits

Life insurance

Hillenbrand, Inc. automatically provides basic life insurance through ING at no cost to you. Your benefit is determined by your respective collective bargaining agreement (CBA). For more information about your coverage, refer to the plan's SPD.

Accidental Death and Dismemberment (AD&D) insurance

AD&D insurance provides coverage if you die accidentally or become seriously injured. Hillenbrand, Inc. automatically provides basic AD&D insurance through CIGNA at no cost to you. Your benefit is determined by your respective Collective Bargaining Agreement (CBA). For more information about your coverage, refer to the plan's SPD.

Voluntary Accidental Death and Dismemberment (AD&D) insurance

Hillenbrand, Inc. also offers voluntary AD&D coverage, which is offered through CIGNA. You can elect coverage up to a benefit amount of $500,000. Amounts over $300,000 cannot exceed 10 times your annual compensation.

Coverage options include single employee or family. This benefit is paid with after-tax dollars.

Disability insurance

Hillenbrand, Inc. automatically provides short-term disability insurance, at no cost to you. Your disability coverage will be determined by the terms of your respective Collective Bargaining Agreement (CBA).

Employee Assistance Program (EAP) coverage

Hillenbrand, Inc. provides EAP coverage, at no cost to you, through Horizon Health. The EAP is available to help you and your dependents address personal problems before those problems become to serious. For more information about your coverage, go to www.horizoncarelink.com. Login ID: Hillenbrand; Password: EAP.

Please note: If your spouse works for Hillenbrand, Inc. and you are both eligible for voluntary AD&D insurance, you and your spouse may only be covered individually under the plans. If you are eligible as an employee, you may not be covered as a dependent of another employee.

This is a summary of benefits only. A complete description of benefits and limitations will be provided in the certificate of coverage on file with Hillenbrand, Inc.

Flexible Spending Accounts

As health care and child care costs continue to rise, you may want to consider enrolling in a Flexible Spending Account (FSA) to stretch your dollars further. Hillenbrand, Inc. has partnered with Health Design Plus to provide all your FSA benefits. Even if you do not participate under the company's health care benefits, you may contribute to one or both FSAs to be reimbursed for eligible expenses.

Save hundreds of dollars on your out-of-pocket health care and child care expenses.

An FSA enables you to set aside before-tax dollars directly from your paycheck (as with your 401(k) plan) to pay for eligible expenses that are not covered by your other plans. This lowers your taxable income and the income tax you pay now. When you pay for eligible health and child care expenses on a before-tax basis, depending upon your tax rate, **your tax savings will be between 10% and 35% on each dollar you spend.**

You pay for each eligible expense up front and are reimbursed with before-tax dollars from your account by the plan's administrator. For a complete list of eligible FSA expenses, refer to the "More Benefits Information" link on Hillenbrand, Inc. Benefits Online. Hillenbrand, Inc. offers the following types of FSAs:

Health Care FSA – You can set aside any amount between $260 and $3,000 each year to pay for common items such as office visit copayments, plan deductibles, prescription drug copayments, prescription eyeglasses, contacts, and some over-the counter medications. For more information, log on to the IRS website at www.irs.ustreas.gov to read IRS publication 502, *Medical and Dental Expenses*.

A Health Care FSA might be right for you if you:

- Have health care expenses for you or your family that are not covered by your health care, dental, or vision plans
- Expect to pay out-of-pocket deductibles and/or copays for health coverage and prescription drugs
- Anticipate other medical expenses such as eyeglasses, orthodontic expenses, and some over-the counter medications.

Dependent Care FSA – You can set aside any amount between $520 and $5,000 each year to pay for qualified dependent care expenses so you and your spouse can work or attend school full time.

A Dependent Care FSA may be right for you if you:

- Need child care for a child or children under the age of 13
- Have expenses for the care of a physically or mentally disabled parent, child, or other relative of any age whom you claim as a dependent for federal tax purposes

Important – There is also a federal tax credit available for eligible child care expenses. Depending on your situation, one may be more advantageous than the other. For more information, log on to the IRS website at www.irs.ustreas.gov to read IRS publication 503, Child and Dependent Care Expenses, or discuss these options with your tax advisor.

continued

Flexible Spending Accounts *continued*

	With Health Care FSA	Without Health Care FSA
Annual pay before taxes	$35,000	$35,000
Annual contribution	$1,500	$0
Taxable income	$33,500	$35,000
Federal, state, and Social Security taxes	$7,610	$7,985
After-tax health care expenses	$0	$1,500
Take-home pay	$25,890	$25,515
FSA tax savings*	$375	$0

* Sample tax savings for a single taxpayer with no dependents. Actual savings will vary based on your individual tax situation.

Fast facts on FSAs

You may participate in the Health Care and/or Dependent Care FSA. Money contributed to the Health Care FSA cannot be used for dependent care expenses and vice versa.

The money you contribute can be used to reimburse only those expenses incurred during the 2012 (January 1, 2012 – December 31, 2012) plan year. **Any money left in an FSA at the end of the run-out period (March 31, 2013) must be forfeited.** It is important to note that you can change your contribution amount during the plan year only if you experience a qualified life event (maximum contribution limits still apply).

Using your FSA debit card

If you elect to contribute to the Health Care FSA, Health Design Plus will automatically send you a debit card equal to the total coverage amount you elected. You will be able to use this debit card throughout the year to cover eligible health care expenses. Although you will be using a debit card for your FSA purchases, you must remember to keep your receipts for these purchases. The receipts will help you reconcile your FSA expenses at the end of the year. To check the balance of your Health Care FSA account, please log on to www.hdplus.com or call Health Design Plus.

Filing an FSA claim for the Dependent Care FSA

You are responsible for mailing or faxing dependent care receipts directly to Health Design Plus.

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Not sure how much to contribute?

The FSA calculator on Hillenbrand, Inc. Benefits Online helps you estimate your out-of-pocket expenses and helps you decide how much to contribute to your FSA.

Enrollment instructions

To enroll or make changes virtually 24 hours a day, 7 days a week

1) **Access the online system at www.hillenbrandinc.mercerhrs.com:**

   You will need the following information to log on:

- Your **Social Security number**. Please enter it without any spaces or dashes. For example, if your Social Security number is 123-45-6789, enter 123456789.
- Your **Password**. If this is your first time visiting the website or calling the plan's toll-free number, your Password has been set to the month and day (MMDD) of your birth. For example, if you were born on April 17, your Password would be 0417. Once you log on, you will be asked to change your password to a new four-digit code.

  If you forget your Password, you can reset it online. Just verify your identity by answering your security question. If you're unable to answer the security question, call 1-866-470-0846 to have your Password reset over the phone.

2) **Follow the simple, step-by-step process to make your benefit elections**

   If you have completed the corresponding checklist included on your Personalized Enrollment Worksheet, keep it handy to make your benefit elections even easier.

3) **Be sure to click "Submit"**

   For security purposes, partial enrollments will not be saved. Please be sure to click "Submit" and print the confirmation page for your records.

4) **Print Confirmation Statement**

   When you have finished enrolling in your benefits, be sure to print your Confirmation Statement.

5) Fax or mail all dependent verification documents to the Hillenbrand, Inc. Benefits Center.

6) Provide your dependents' Social Security numbers as soon as they are available.

Have you designated a beneficiary?

Don't forget to designate a beneficiary for all of your life insurance benefits. Even if you waive elective coverage, you must designate a beneficiary for the company-provided plans. To review or update your beneficiary information, log on to Hillenbrand, Inc. Benefits Online or call the Hillenbrand, Inc. Benefits Center.

For personal assistance with benefit elections

Please call 1-866-470-0846, Monday through Friday, between 9:00 a.m. and 6:00 p.m. Eastern Time to speak with a Service Representative.

Creditable Coverage Notice

Important Notice from Hillenbrand, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Hillenbrand Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Hillenbrand Inc. has determined that the prescription drug coverage offered by the Hillenbrand, Inc. Health Care Plan ("plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current Hillenbrand, Inc. coverage will not be affected. For most persons covered under the plan, the plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the plan's Summary Plan Description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Hillenbrand, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the plan, pursuant to the plan's eligibility and enrollment rules. You should review the plan's Summary Plan Description to determine if and when you are allowed to add coverage.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with Hillenbrand, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage…

Contact the Hillenbrand, Inc. Benefits Service Center listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Hillenbrand, Inc. changes. You also may request a copy of this notice at any time.

For more information about your options under the Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage can be found in the "Medicare & You" handbook. You'll receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember!

Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2012
Name of Entity/Sender:	Hillenbrand, Inc.
Contact-Position/Office:	Hillenbrand, Inc. Benefits Service Center
Phone Number:	1-866-470-0846

Nothing in this notice gives you or your dependents the right to coverage under the plan. Your (or your dependents') right to coverage under the plan is determined solely under the terms of the plan.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 60 days after your or your dependent's other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Hillenbrand, Inc. Benefits Center
P.O. Box 9735
Providence, RI 02940

Notes

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Ready to make your benefit elections?

Log on to www.hillenbrandinc.mercerhrs.com within 31 days of your eligibility date. See page 19 for detailed instructions.

Have questions or need personal assistance?

Call 1-866-470-0846, Monday through Friday, between 9:00 a.m. and 6:00 p.m. Eastern Time to speak with a Service Representative.

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas.

This guide contains only highlights of the Hillenbrand, Inc. Benefits Program. Every effort has been made to report information accurately, but the possibility of error exists. In addition, not every plan detail of every benefit that may matter to you could be included in this guide.

The Hillenbrand, Inc. Benefits Program is governed by an official plan document. In case of any conflict between this guide and an official plan document, the plan document will be the final authority.

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