SUMMARY OF MATERIAL MODIFICATION (SMM)
TO THE
SUMMARY PLAN DESCRIPTION FOR THE
BARNES GROUP INC. CONSOLIDATED PENSION PLAN
PARTS C & D – HOURLY EMPLOYEES
(As Amended and Restated Effective December 31, 2016)

Barnes Group Inc. (the "Company"), the plan sponsor of the *Barnes Group Inc. Consolidated Pension Plan Parts C & D - Hourly Employees* (the "Plan"), has amended the Plan's claims procedures for disability-related claims, effective as of April 1, 2018. The provision entitled "*Claims Procedure*" in your Summary Plan Description for the Plan (the "SPD") has been replaced in its entirety, effective as of April 1, 2018, with the following, :

CLAIMS PROCEDURE

Presenting a Claim for Benefits

If you believe you are being denied any rights or benefits under the Plan, you (or your duly authorized representative) may file a claim in writing with the Benefits Committee or its delegate.

If your claim is wholly or partially denied, the Benefits Committee will notify you in writing (or electronically if permissible under applicable law) of its decision within a reasonable period of time, but not later than 90 days (45 days in case of a disability-related claim) after the date the Benefits Committee received your claim. The notice will contain the following information:

- The specific reason or reasons for the denial,
- Specific reference(s) to the Plan provisions on which the denial is based,
- A description of any additional material or information necessary in order to present a thorough appeal and an explanation of why such material or information is necessary, and
- A description of how to have your claim reviewed.

For disability-related denials, the notice of denial will also address the following:

- A discussion of the decision, including an explanation of the basis for agreeing or disagreeing with any of the following:
    - The views of the health care professionals treating you or vocational professionals evaluating you;
    - The views of medical or vocational experts obtained by the Benefits Committee, whether or not relied upon in making the denial; and
    - Any disability determination of the Social Security Administration on your disability status.

- If the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgement for the denial, as applied to you, or a statement that such an explanation will be provided free of charge.

- The specific internal rules, guidelines, protocols, standards or similar criteria of the Plan relied upon in making the denial or a statement that no such rules, guidelines, protocols or standards exist.

- A statement of your reasonable access, free of charge, to documents, records and information relevant to your claim.

If the Benefits Committee or its delegate determines in its sole discretion that an extension of time for processing the claim is required, you will be notified of the extension in writing within the original 90-day period (or 45-day period in the case of a disability-related claim). In no event will the extension exceed a period of 90 days (30 days in the case of a disability-related claim) (a second 30-day extension may also be necessary)) from the end of the original 90-day period (45-day period in the case of a disability-related claim). The extension notice will indicate the special circumstances requiring an extension and the date by which the Benefits Committee or its delegate expects to render the determination.

For a disability-related claim, a notice of extension contains the following information:

- The standards on which entitlement to a disability-related benefit is based;

- Any unresolved issue(s) that prevents a decision on the claim;

- Any additional information needed to resolve the issue(s) and provision of at least 45 days for you to provide such information to the Benefits Committee.

Access to Information and Documents

If your claim is denied, you may request and receive reasonable access to and copies of relevant documents, records and other information in the Company's possession free of charge. Relevant documents, records and other information are those that:

1. were relied on in making the determination;

2. were submitted, considered or generated in the course of making the determination; or

3. demonstrate compliance with the Plan's administrative processes or safeguards.

Appeals

If you disagree with the decision, you may appeal the denial to the Benefits Committee or its delegate. Your request must be made in writing by you or your duly authorized representative to the Benefits Committee or its delegate within 60 days after the Benefits Committee's notice of denial. As part of this request, you (or your duly authorized representative) may:

- Submit written issues and comments to the Benefits Committee or its delegate, and

- Review relevant documents, records and information (and request copies free of charge).

This review will consider all comments, documents and other information that you (or your duly authorized representative) submit, without regard to whether such information was previously submitted or considered. The decision on review will be delivered in writing (or electronically if permissible under applicable law) within 60 days (45 days for claims involving disability benefits) or 120 days (90 days for claims involving disability benefits) if the Benefits Committee or its delegate determines in its sole discretion special circumstances warrant additional time and you are notified of the extension in writing within the original 60-day period (45-day period for claims involving disability benefit claims) after your request for review.

For an appeal of a disability-related claim, the review shall not afford deference to the initial benefit determination and shall be conducted by a person who is neither the person who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such person. If a claim is denied due to a medical judgment, the reviewer will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The healthcare professional consulted will not be the same person consulted in connection with the initial benefit decision (nor be the subordinate of that person). The decision on review will identify any medical or vocational experts who advised the reviewer in connection with the benefit decision, even if the advice was not relied upon in making the decision.

For an appeal of a disability-related claim, the Benefits Committee or its delegate will provide you, free of charge, any new or additional evidence to be considered, relied on or generated by the person making the determination on the appeal and will give you a reasonable time to respond to the information prior to the date the decision on the appeal is due . Also, if the Benefits Committee considers a new or additional rationale for denial of your appeal, the Benefits Committee or its delegate will provide you with that rationale and a reasonable time to respond to that rationale prior to the date the decision on the appeal is due.

If your claim is again denied on appeal, the decision will inform you of the specific reasons for the denial and will include references to the pertinent Plan provisions. The decision will also advise you of your rights to review or request (free of charge) copies of relevant documents, records and other information relevant to your claim for benefits. You will also be advised of your right to bring a civil action under ERISA.

If your disability-related claim is denied on appeal, the decision will also address the following:

- A discussion of the decision, including an explanation of the basis for agreeing or disagreeing with any of the following:

    - The views of the health care professionals treating you or vocational professionals evaluating you;

    - The views of medical or vocational experts obtained by the Benefits Committee, whether or not relied upon in denying the appeal; and

- Any disability determination of the Social Security Administration on your disability status.

- If the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgement for the denial, as applied to you, or a statement that such an explanation will be provided free of charge.

- The specific internal rules, guidelines, protocols, standards or similar criteria of the Plan relied upon in making the denial or a statement that no such rules, guidelines, protocols or standards exist.

Finality of Review on Appeal

You may not challenge the Benefit Committee's (or its delegate's) determinations in judicial or administrative proceedings without first complying with the Plan's claims procedures. The decisions made pursuant to these procedures are final and binding; provided, however, that once you have exhausted the administrative claims procedures, you may seek a review of your claim before a court of competent jurisdiction within twelve (12) months of the date your claim is finally denied.

Failure to Follow the Claim Procedures

If the Plan fails to follow the claims procedures as written, you will be deemed to have exhausted the administrative remedies available and you are entitled to pursue available remedies under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. However, *de minimus* violations of the claims procedure by the Plan will not result an exhaustion of administrative remedies.

Please refer to your Summary Plan Description for additional information regarding the Plan. Any questions can be directed to the Benefits Committee at Barnes Group Inc. at:

Barnes Group Inc. Benefits Committee
Barnes Group Inc.
123 Main Street
Bristol, CT 06010

This notice is intended to serve as a Summary of Material Modification under Sections 102(a) and 104(b) of ERISA. You should keep a copy of this notice with your copy of the Summary Plan Description for future reference.

IF THIS SMM HAS BEEN DELIVERED TO YOU BY ELECTRONIC MEANS, YOU HAVE THE RIGHT TO RECEIVE A WRITTEN SUMMARY AND MAY REQUEST A COPY OF THIS SUMMARY ON A WRITTEN PAPER DOCUMENT AT NO CHARGE BY CONTACTING THE PLAN ADMINISTRATOR.

Your rights under the Plan are governed by the provisions of the Plan Document and related Trust Agreement. In the event of any conflict between this SMM or the SPD and the provisions of the Plan Document, the provisions of the Plan Document will control.

Plan Name: Barnes Group Inc. Consolidated Pension Plan -
Part C and Part D of the Plan (Hourly Employees)
Plan Number: 002
Plan Year: January 1 – December 31
Plan Sponsor/Administrator: Barnes Group Inc.
Plan Sponsor EIN: 06-0247840
Trustee: Bank of New York Mellon
Legal Service: Plan Administrator or Trustee