SUMMARY PLAN DESCRIPTION

FOR

BARNES GROUP INC.
PRESCRIPTION DRUG PLAN

Effective January 1, 2023

This summary plan description is with respect to a component program of the Barnes Group Inc. Health and Welfare Plan (Plan No. 518)

If this document has been delivered to you by electronic means, you have the right to receive a written document and may request a copy of this document on a written paper document at no charge by contacting the Plan Administrator.

BARNES GROUP INC.
PRESCRIPTION DRUG PLAN
(Component of the Barnes Group Inc. Health and Welfare Plan (Plan No. 518))

One of the important ways of maintaining your health is by providing you access to quality, cost-effective medications and choice when it comes to getting your medications. The Barnes Group Inc. Prescription Drug Plan (the "Plan") is designed to make quality prescription drugs available to participants at a lower cost. The Plan has partnered with CVS Caremark to provide prescription drug benefits. CVS Caremark serves as the pharmacy benefits manager and administers the prescription drug card program.

This Plan is a component program of the Barnes Group Inc. Health and Welfare Plan (Plan No. 518). You must be enrolled in the Meritain Medical Plan under the Barnes Group Inc. Health and Welfare Plan (Plan No. 518) to receive prescription drug coverage. If you are enrolled in the Meritain Medical Plan under the Barnes Group Inc. Health and Welfare Plan (Plan No. 518) then you, and your enrolled dependents, are automatically enrolled in the prescription drug coverage options administered by CVS Caremark under the Plan. Following your enrollment in the Meritain Medical Plan under the Barnes Group Inc. Health and Welfare Plan (Plan No. 518) you will receive a separate ID card for prescription drug coverage which you will need to have to have a prescription filled at a participating pharmacy or to order your prescriptions.

The benefits under the Plan are outlined in this Summary Plan Description ("SPD"). We will also tell you about other important information concerning the Plan, such as the laws that protect your rights. Read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator. The Plan Administrator contact information can be found on page 15.

This SPD presents an overview of your prescription drug benefits, provisions and programs offered by the Plan. This SPD should be read in conjunction with the Barnes Group Inc. Health and Welfare Plan (Plan No. 518).

Prescription Drug Benefits Under the Plan

Prescription drug benefits are payable for covered prescription expenses incurred by you or your dependents who are enrolled in the Plan. The Plan covers most drugs that legally require a prescription and have Federal Drug Administration ("FDA") approval for treatment of the specified conditions. Drugs available without a prescription, classified as "over the counter" (OTC) are not covered regardless of the existence of a physician's prescription unless ACA mandated.

Benefits for prescription expenses incurred at a pharmacy are payable in accordance with and as shown on the Summary of Benefits attached as **Appendix A** and incorporated herein by reference.

You are responsible for payment of:

- The co-payment or co-insurance. Co-payments or co-insurance are based on the category (generic, brand name, formulary and non-formulary) and place of purchase (retail pharmacy or mail order pharmacy)

- The deductible (if applicable);

- The cost of any medication not covered under the prescription drug benefit; and

- The cost of any quantity of medication dispensed in excess of the day supply noted on the Summary of Benefits.

> ***Note: Any third-party prescription discounts or cost supplements will NOT be applied to you or your dependents' deductibles or out-of-pocket limits under the Plan.***

Generic, Brand Name and Preferred Drugs

The Plan encourages utilization of (a) generic medications and (b) preferred drugs comprising the CVS Caremark Formulary list.

"Brand Name" means a drug manufactured and marketed under a trademark, or name by a specific drug manufacturer. "Generic" means a medication chemically equivalent to a brand name drug on which the patent has expired. A generic drug is identical to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. Although a generic drug is chemically identical to its branded counterpart, it is typically sold at substantial discounts from the branded drug's price.

You will pay the standard copayment for a generic medication if a generic drug is available. If your doctor writes a prescription stating that a Generic may be dispensed, Barnes Group will only pay for the Generic drug. If you choose to buy the Brand Name drug in this situation, you will be required to pay the Brand Name co-pay plus the difference between the Generic and Brand Name drug cost. If

your doctor prescribes a covered Brand Name prescription drug where a Generic prescription drug equivalent is available and specifies “Dispense As Written” (DAW), you will only pay the co-payment for the Brand Name prescription drug.

CVS Caremark has a list of preferred prescription medications that have been chosen because of their clinical effectiveness and safety. This preferred drug list or formulary, offers a wide selection of Generic and Brand Name prescription drugs. This list is updated from time to time. In order to encourage formulary compliance the program assesses a higher co-payment on prescriptions filled with non-preferred (non-formulary) drugs.

To save money, have your doctor or other prescriber choose a Generic or preferred Brand Name medication from the CVS Caremark preferred drug list, if appropriate. You may access the preferred drug (formulary) list at www.caremark.com or by calling Customer Care toll-free at 1-800-552-8159.

Barnes Group offers a unique Preventive Generics Medication Program designed to promote medication compliance by offering free generic medications included on the CVS Caremark Preventive Generic Formulary covering more than 14 different diagnostic condition categories and more than 270 generic medications.

Medications on this Preventive Generics listing will also bypass the deductible if you are enrolled in one of our HSA Plans.

For a complete list of current medications available under this program, please review the listing on the Barnes Next360 website at www.barnesgroupbenefits.com.

Ways to Fill Your Prescriptions.

Participating Retail Pharmacies: 30-day supply.

Filling your prescription at a participating retail pharmacy is the most convenient and cost-efficient option when filling a prescription for your immediate and short-term medications. Short term medications are generally taken for a limited amount of time and have a limited amount of refills, such as antibiotics for strep throat or pain relievers for an injury. You can fill prescriptions for these medications any participating pharmacy in the CVS Caremark retail network. A participating retail pharmacy is one which has entered into an agreement with CVS Caremark. Simply present your combined medical and pharmacy ID card and written prescription to your pharmacist at the participating retail pharmacy, and pay your copayment as shown on the Summary of Benefits. The participating pharmacy will submit your prescription drug claim electronically on your behalf, and you will not need to submit a Prescription Reimbursement Claim Form.

You can locate the nearest participating retail pharmacy at any time at www.caremark.com or by calling Customer Care toll free at: 1-800-552-8159.

CVS Caremark Mail Order Pharmacy and Retail Pharmacy.

The CVS Caremark Mail Order Pharmacy is a convenient and cost-effective way for you to order up to a 90-day supply of long-term (maintenance) medications. Maintenance medications treat an ongoing medical condition, such as high blood pressure, diabetes, asthma or contraception. You can have your long-term medication delivered to your home, office or a location of your choice with free standard shipping.

The CVS Caremark Mail Order pharmacy provides the following benefits:

- A 90-day supply of the maintenance medication delivered to your home with free standard shipping;
- Confidential, tamper-resistant and temperature-controlled packaging of your medication;
- The ability to refill your prescription on-line at www.caremark.com, by phone by calling CVS Caremark's Customer Care toll free number 1-800-552-8159, or by mail.

Mail Order. To use the CVS Caremark Mail Order pharmacy, ask your physician to write a new prescription for a 90-day supply of the maintenance medication with up to three refills. Then complete the Mail Service Order Form (which can be found at www.caremark.com) and mail the order form, along with the original prescription you received from your physician and your copay to:

CVS Caremark
P.O. Box 94467
Palatine, IL 60094-4467

Local CVS Pharmacy. In addition to using the CVS Caremark Mail Order pharmacy, you can refill a prescription for a maintenance medication by visiting a local CVS pharmacy to obtain a 90-day supply for the same copay as the CVS Caremark Mail Order pharmacy.

Non-Participating Retail Pharmacies.

Non-participating pharmacies are those pharmacies that have not agreed to participate in the CVS Caremark network. In most cases if you attempt to fill a prescription at a non-participating pharmacy, the claim will "reject" as non-participating provider or will process at the full cost of your medication. The only instance in which your prescription may be accepted and processed at a non-participating pharmacy is when you are out of the country and have an urgent need, which does not constitute experimental treatment.

Prior Authorization, Quantity Limits Under the Prescription Drug Program

Prior Authorization.

Some medications require mandatory prior authorization, meaning you will need to meet certain medical criteria prior to the prescription being is filled. Certain medications require prior authorization before coverage is approved to assure medical necessity, patient safety, clinical appropriateness and/or cost effectiveness. If prior authorization is required and you do not obtain the approval before the prescription is filled, the cost of the prescription will not be covered. The list of medications that require prior authorization is available upon request and subject to change at any time. Failure to comply with the prior authorization requirements will result in no coverage for the specific prescription.

Quantity Limits.

Some prescription medications have specific dispensing limitations for quantity and maximum dose. This means there are limits on the amount of prescription drug that can be dispensed to you by any participating pharmacy in a specified period of time. Quantity limits encourage safe, effective and economic use of drugs. The list of medications subject to quantity limits is available upon request and subject to change at any time. Failure to comply with the quantity limits will result in no coverage for the specific prescription.

As a reminder, your plan includes a specialty generic first program which promotes the use of generic specialty medication first before certain brands. CVS will provide physician outreach to see if a generic is an option verses the brand product.

Drugs Covered Under the Prescription Drug Program*

The following prescription drugs generally are covered under the program unless they are specifically excluded as noted below:

Covered Medications*

- Legend Drugs (drugs that require a prescription) **Exceptions**: See Exclusion list below.
- Compounded medication of which at least one ingredient is a legend drug at a participating pharmacy. Compounded medications equal to or exceeding $300 per script will require prior authorization.
- ACA mandated contraceptives, including but not limited to the following: Oral, Transdermal, Intravaginal and Injectable; extended cycle products are subject to 3x retail copays for a 90 day supply
- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips, Disposable insulin needles/syringes/lancets
- ADD/ADHD Medications (prior authorization required over age 18)
- Androgens (prior authorization required)
- Topical Acne Agents (prior authorization required over age 34)
- Narcolepsy Medications (prior authorization required)
- Growth Hormones (prior authorization required)
- Hypnotics (quantity limits apply)
- Extended Release Controlled Substances (quantity limits apply)
- Gastrointestinal-Antiemetics (quantity limits apply)
- Influenza Agents (quantity limits apply)
- Migraine Medications (quantity limits apply)
- Oral/Intranasal/Topical Fentanyl (prior authorization required)
- Hemophilia medications

Plan Exclusions*

- Biological sera, allergy sera and extracts, blood, blood plasma, blood products with exception list above, immunological agents, Non-ACA immunization agents or any substitutes.

- Cosmetic drugs, medications or preparations used for cosmetic purposes or to promote hair growth, including, but not limited to health & beauty aids, chemical peels, dermabrasion, treatments, bleaching, creams, ointments or other treatments or supplies to remove tattoos, scars or alter appearance or texture of skin.
- Compounded prescriptions that use ingredients such as bulk chemicals, high cost powders, and compound kits
- Contraception, with the exception list above, but not limited to: condoms, or any services associated with the prescribing, monitoring and/or administration of contraceptives.
- Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the Plan Inclusions section.
- Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy in oral, injectable and topical forms or any other form used internally or externally (including but not limited to gels, creams, ointments and patches). Any prescription drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or any other prescription drug that is in a similar or identical class; or has a similar or identical mode of action or exhibits similar or identical outcomes.
- Sexual dysfunction/enhancement: Any drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including: drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ.
- Injectables: Any charges for the administration/injection of injectable insulin; Injectable drugs dispensed by out-of-network pharmacies; Needles and syringes, except for diabetic needles and syringes.
- Prescription and OTC smoking cessation product which exceed the 168 day limit for ACA required coverage per calendar year.
- Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.
- Drugs used for the purpose of weight gain or reduction, including but not limited to: stimulants; preparations; foods or diet supplements; dietary regimens and supplements; food or food supplements; appetite suppressants; and other medications.
- Drugs used for the treatment of obesity.
- Charges in excess of the benefit, dollar, day, or supply limits stated.
- Any drugs, medications, services and supplies that are not medically necessary, for the diagnosis, care or treatment of the illness or injury involved. This applies even if they are prescribed, recommended or approved by your physician or dentist.
- Over- the-counter (OTC) medications are excluded from coverage even if a prescription is written unless the product is ACA mandated for required coverage.
- Food items: Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition (except in NJ or states that require it).
- Prescription Vitamins unless listed above
- Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
- Durable medical equipment, monitors and other equipment.
- Supplies/devices/equipment of any type, except as specifically referenced for diabetic supplies and specialty medications.
- Test agents except diabetic test agents.

- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.
- Experimental or investigational drugs or devices, except as described in the What the Plan Covers section. This exclusion will not apply with respect to drugs that: Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and CVS Caremark determines, based on available scientific evidence, are effective/show promise of being effective for illness.
- Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.
- Prescription drugs dispensed by an out-of-network pharmacy or provided through a third party vendor contract with the contract holder, including prescription drugs, medications, injectables or supplies.
- Patient assistance programs may not apply to deductible and out of pocket accumulations.
- Drugs, services and supplies provided in connection with treatment of an occupational injury or occupational illness.
- Drugs given by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.
- Administration or injection of any drug. Drugs given or entirely consumed at this time and place it is prescribed or dispensed.
- Non-emergency charges incurred outside the US (1) if you traveled to such location to obtain the drugs or supplies, even if otherwise covered, or (2) such drugs or supplies are unavailable or illegal in the US, or (3) the purchase of such drugs or supplies outside the US is considered illegal.
- Prescription orders filled prior to the effective date/after term date of coverage under this Booklet.
- Refills in excess of the amount specified by the prescription order.
- Replacement of lost or stolen prescriptions.
- Formulary Exclusion Lists

**Quantity limits may apply based on the Food and Drug Administration's dosage guidelines*.

These lists are not all-inclusive and subject to change at any time. Contact customer service at 1-800-552-8159 for specific drug coverage information.

The Plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive items and services at 100% and ensures these items and services are not subject to deductibles or other limitations such as annual caps or limits. You can contact 1-800-552-8159 if you have specific drug questions or register at www.caremark.com to check drug costs and coverage.

Specialty Medications. Specialty medications are those that require special handling, administration, or monitoring and are not included in the list of covered drugs above. Specialty medications must be ordered through the CVS Caremark Specialty Pharmacy at 1-800-237-2767 ***after obtaining prior authorization***. The member should call the above number, provide your contact information, a form of payment along with the physician's name and number for the authorization department to reach out for the prescription.

Claims and Appeal Procedures

Most prescription drug claims will be submitted electronically by the pharmacy; however, if a claim is not submitted electronically, you must pay for the prescription in full at the time of purchase. In order to be reimbursed for the prescription, you must complete a prescription reimbursement claim form and mail the claim form, along with a copy of the receipt to the address printed on the form. A copy of the form can be found at www.caremark.com.

If a prescription drug claim is wholly or partially denied, you or your authorized representative has the right to appeal the decision. You or your authorized representative may appeal the denial no later than 180 days after receiving notice of an adverse claim decision. Appeals of prescription drug claims are handled by CVS Caremark and are decided in accordance with the terms of the plan document.

First Level Appeal: Initial Benefit Reconsideration. The appeal process takes into consideration any relevant and supporting documentation which may include a copy of the initial denial letter, your medical records and documentation, plan language, and other relevant information, etc. An appeal request should be made to CVS Caremark in writing at the address or facsimile number included in the initial denial letter. However, in the case of an appeal of an urgent care claim, your physician may make the appeal request by telephone.

Upon receipt of the relevant and supporting documentation, an appeals analyst will review and determine an appeal relating to non-clinical benefits (*e.g.*, eligibility determinations, copay issues, specific exclusions under the prescription drug care program), and an appeals pharmacist will review and determine an appeal relating to benefits that may require clinical knowledge (*e.g.*, prior authorization denials). Your appeal will be processed within the following time frames after receipt of the claim, unless additional information is needed to make a determination:

Pre-Service Claim (including a prior authorization)	15 days
Post Service Claim	30 days
Urgent Care Claim	72 hours

All appeal determinations, other than determinations regarding prior authorization requests described below, are final subject to review only for abuse of discretion.

Second Level Appeal for Prior Authorization Requests: Medical Necessity and Independent Specialist Physician Review. If a prior authorization request is denied, you or your authorized representative may request another review. A request must be made within ***180 days after receiving notice of an adverse claim decision on appeal.*** An independent external review organization will conduct a review of the denial. CVS Caremark will forward to the independent external review organization the applicable medical records and documentation, plan language, and other relevant information. An independent specialist physician may ask you or your authorized representative for additional information he considers necessary or potentially useful in his review. The independent specialist physician will prepare a written determination in support of his final decision, which will be forwarded to CVS Caremark to communicate to you or your representative.

For More Information About the Prescription Drug Card Program

The Plan has partnered with CVS Caremark to provide prescription drug benefits. CVS Caremark serves as the pharmacy benefit manager and administers the prescription drug card program. The site www.caremark.com, is designed to help you explore ways to track your benefits, and you can use the site to locate pharmacies and compare prescription drug costs. If you have any questions about the prescription drug card program, contact:

CVS Caremark Customer Care Phone
800-552-8159

Other Plan Information

Your Personal Health and Prescription Information

In order to provide you with pharmacy services and to administer your prescription-drug benefit, CVS Caremark may require personal health and prescription-drug information from you, your doctor or your retail pharmacy. CVS Caremark only uses this information to verify your identity and pricing under the program; to check for adverse drug interactions; to accurately process your prescription order; and to keep you informed about the proper use of your medications, available treatment and benefit options.

Under the terms of our contract with Barnes Group Inc., CVS Caremark is required to provide individual pharmacy claims data for payment processing and record-keeping without identifying individual members. As part of the contract, CVS Caremark is obligated to report any unusual activity that may constitute fraud or abuse of benefits. Barnes Group Inc. and CVS Caremark also may use information and prescription data gathered from claims submitted for reporting and analysis purposes without identifying individual members.

HIPAA Compliance and Information Privacy

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") includes provisions to ensure privacy of your personal health information. CVS Caremark is committed to meeting both the HIPAA and Barnes Group guidelines related to protecting your privacy.

Your Rights under ERISA

Participants, eligible employees and other employees of Barnes Group Inc. may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA") and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

(a) examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;

(b) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for the copies;

(c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and

(d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement, or about your rights under ERISA or HIPAA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Continuation Coverage Rights under COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. When you or your covered dependents

become eligible for COBRA, the Plan Administrator will provide you with detailed information on continuing your health coverage. Whenever "Plan" is used in this section, it means any of the health benefits under the Barnes Group Inc. Health and Welfare Plan (Plan No. 518), and its component Barnes Group Inc. Prescription Drug Plan.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer's notice of this COBRA continuation right, if later.
- Agree to pay the required contributions.

1. Who Qualifies for COBRA?

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights. Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
Your marriage is annulled, you divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the Plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

2. Disability May Increase Maximum Continuation to 29 Months
If you or your covered dependents qualify for disability status under Title II or XVI of the Social Security Act during the 18-month continuation period, you and your covered dependent:

- Have the right to extend coverage beyond the initial 18-month maximum continuation period.
- Qualify for an additional 11-month period, subject to the overall COBRA conditions.
- Must notify the Plan Administrator within 60 days of the disability determination status and before the 18-month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the contributions after the 18th month, through the 29th month.

A covered dependent could qualify for an extension of the 18 or 29-month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

3. Determining Your Contributions For Continuation Coverage
Your contributions are regulated by law based on the following:

- For the 18 or 36-month periods, contributions may never exceed 102 percent of the Plan costs.
- During the 18 through 29-month period, contributions for coverage during an extended disability period may never exceed 150 percent of the Plan costs.

4. When You Acquire a Dependent During a Continuation Period
If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the Plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent under the Plan,
- The Plan Administrator is notified about your dependent within 31 days of eligibility, and
- Additional contributions for continuation are paid on a timely basis.

5. When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29, or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is neither disabled nor eligible for an extended maximum).
- You and your covered dependents do not pay required contributions.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this Plan may remain in effect until the pre-existing condition clause ceases to apply or the maximum continuation period is reached under this Plan.
- The date Barnes Group Inc. no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

6. Conversion from a Group to an Individual Plan

You may be eligible to apply for an individual health plan, please review the provisions of your applicable health plan document.

General Plan Information

This document is a summary of the key features of the Prescription Drug Plan. As a summary, this document cannot fully describe every aspect of the pharmacy program. Please note the CRD plan document between CVS Caremark and Barnes Group Inc. will supersede in the event there are discrepancies between this document and the CRD plan documents.

Name of Plan:	Barnes Group Inc. Prescription Drug Plan (component program of the Barnes Group Inc. Health and Welfare Plan)
Plan Number:	518
Plan Sponsor:	Barnes Group Inc. 123 Main Street Bristol, CT 06010
Plan Administrator:	The name, address and business telephone number of the Plan's Administrator are: Senior Vice President, Human Resources Barnes Group Inc. 123 Main Street Bristol, CT 06010 Telephone: (860) 583-7070
Plan Sponsor EIN:	06-0247840
Pharmacy Benefit Claim Administrator:	CVS Caremark, Inc. Headquarters One CVS Drive Woonsocket, RI 02895 (Paper Claims) P.O. Box 52116 Phoenix, AZ 85072

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

If you have any questions, please contact the Plan Administrator.

APPENDIX A
BARNES GROUP INC. PRESCRIPTION DRUG PLAN
(Component of the Barnes Group Inc. Health and Welfare Plan (Plan No. 518))

SUMMARY OF BENEFITS		
	RETAIL 30-Day Supply	**MAIL ORDER/ CVS RETAIL** 90-Day Supply
GENERIC MEDICATIONS – Non-Preventive Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	$15	$40
PREFERRED BRAND NAME MEDICATIONS If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	$40	$80
NON-PREFERRED BRAND NAME You will pay the most for medications not on your plan's preferred drug list.	$70	$140
SPECIALTY MEDICATIONS*	Only available mail order via CVS Specialty Pharmacy $220 for a 30-day supply	
PREVENTIVE GENERICS PROGRAM Includes select listing of preventive generic medications only.	$0	$0
*CVS Caremark Specialty medications are only covered through CVS Caremark Specialty Pharmacy and limited to 30-Day supply. Please call **1-800-237-2767** to access this benefit, M-F 7:30am - 9pm EST. For calls after hours, please call the customer care phone number 800-334-8134. **Generic Policy:** If your doctor writes a prescription stating that a Generic may be dispensed, Barnes Group will only pay for the Generic drug. If you choose to buy the Brand Name drug in this situation, you will be required to pay the Brand Name co-pay plus the difference in cost between the Generic and Brand Name drug. If your doctor prescribes a covered Brand Name drug where a Generic is available and specifies "Dispense As Written" (DAW), you will only pay the co-pay for the Brand Name drug.		

Out-of-Pocket Costs
Your prescription drug coverage will vary based on the medical plan, as follows:

POS Choice Plan:
The Calendar year Maximum Out-Of-Pocket (OOP) applies to both medical and pharmacy expenses. Each individual family member must meet the individual OOP ($4,000) unless the family OOP ($8,000) has been met by any two or more covered family members. Once met, your covered prescriptions are paid at 100%. Note: Any penalties will not apply to the OOP.

HSA Advantage Plan:
The Calendar year deductible ($2,000 / $4,000) applies to both medical and pharmacy expenses. One member or any combination of family members can meet the family Deductible. Once the deductible has been met, your covered prescriptions are subject to the Plan copays or coinsurance. Preventive Generic Medications bypass the deductible requirement.

The Calendar year Maximum Out-Of-Pocket (OOP) applies to both medical and pharmacy expenses. All covered prescription expenses (with the exception of any Penalties, third party prescription discounts or cost supplements) accumulate to the plan's Out-of-Pocket Maximum ($4,000/$8,000). One member or any combination of family members can meet the Family Out-of-Pocket (OOP) limit.

HSA Value Plan:
The Calendar year deductible ($3,000/$6,000) applies to both medical and pharmacy expenses. One member or any combination of family members can meet the family Deductible. Once the deductible has been met, your covered prescriptions are subject to the Plan copays or coinsurance. Preventive Generic Medications bypass the deductible requirement.

The Calendar year Maximum Out-Of-Pocket (OOP) applies to both medical and pharmacy expenses. All covered prescription expenses (with the exception of any Penalties, third party prescription discounts or cost supplements) accumulate to the plans Out-of-Pocket Maximum ($5,000/$10,000). Each individual family member must meet at least $8,700 in covered medical and prescription drug expenses unless the family Out-Of-Pocket maximum ($10,000) has been met by any two or more covered family members.

HSA Max Plan:
The Calendar year deductible ($7,050/$14,100) applies to both medical and pharmacy expenses. Each individual family member must meet the individual deductible ($7,050) unless the family deductible ($14,100) has been met by any two or more covered family members. Once the deductible has been met, your covered prescriptions are subject to the Plan copays or coinsurance. Preventive Generic Medications bypass the deductible requirement.

The Calendar year Maximum Out-Of-Pocket (OOP) applies to both medical and pharmacy expenses. All covered prescription expenses (with the exception of any Penalties, third party prescription discounts or cost supplements) accumulate to the plans Out-of-Pocket Maximum ($7,050/$14,100). Each individual family member must meet the individual Out-of-Pocket Maximum ($7,050) unless the family Out-of-Pocket Maximum ($14,100) has been met by any two or more covered family members.

Note: Any third-party prescription discounts or cost supplements will NOT be applied to your or your dependents' deductibles or out-of-pocket limits under the Plan.

Customer Care
If you have questions about your prescriptions or benefits, you can contact Member Services toll-free at 1-800-552-8159.