AMGEN

RETIREE MEDICAL SAVINGS ACCOUNT PLAN
SUMMARY PLAN DESCRIPTION

January
2017
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INTRODUCTION TO THE PLAN

Amgen Inc. adopted the Amgen Inc. Retiree Medical Savings Account Plan as of July 1, 2009, as later amended and restated effective January 1, 2015 (the “Plan”). The Plan is intended to assist you in meeting your medical expenses and those of your eligible dependents after you retire or terminate employment.

Funding for Eligible Medical Expenses is through one or two Accounts established in your name during your working years – an Employee Contributions Account and an Employer Contributions Account (collectively referred to as your “Accounts”). For information on these Accounts, see the section entitled EMPLOYEE AFTER-TAX CONTRIBUTIONS and the section entitled EMPLOYER CONTRIBUTIONS. If you meet the eligibility requirements for the Plan, you will be permitted to make voluntary after-tax contributions to your Employee Contributions Account and Amgen will credit your Employer Contributions Account.

The Employee Contributions Accounts are held in a “voluntary employees’ beneficiary association” (“VEBA”), which is a special type of trust where the earnings on contributions are not taxed. Amounts in your Employee Contributions Account grow tax-free. Following your termination of employment, amounts paid out of your Employee Contributions Account can be used to reimburse Eligible Medical Expenses incurred by you and your other Covered Individuals on a tax-free basis. These contributions plus any Employer Contributions that you may be entitled to receive can be an important tool in saving for your retiree medical needs.

The Employer Contributions Accounts are intended to be unfunded “health reimbursement arrangements” (“HRAs”). Upon retirement, if you meet certain requirements, amounts paid out of your Employer Contributions Account can be used to reimburse Eligible Medical Expenses incurred by you and your other Covered Individuals on a tax-free basis.

**IMPORTANT:** Although the information in this Summary Plan Description is intended to be accurate, the Plan document maintained by Amgen contains all of the specific provisions of the Plan. To the extent that there is any conflict between this summary plan description (“SPD”) and the text of the Plan, the Plan will control.

The Plan is not a contract between you and Amgen and is not consideration for, or an inducement or condition of, your employment. Nothing contained in the Plan gives you the right to be retained in Amgen’s service. The Plan may not be used to restrict Amgen’s right to discharge you at any time, with or without cause. Inclusion under the Plan will not give you any right or claim to any benefit under the Plan or any other program of Amgen, except to the extent such right has specifically become fixed under the terms of the Plan.
### GENERAL ADMINISTRATIVE INFORMATION

<table>
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<th>Name of the Plan:</th>
<th>Amgen Inc. Retiree Medical Savings Account Plan</th>
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<tr>
<td>Effective Date:</td>
<td>July 1, 2009</td>
</tr>
<tr>
<td>Plan Sponsor and Plan Administrator Address and Telephone:</td>
<td>Amgen Inc. (“Amgen”) c/o Amgen Benefits Center One Amgen Center Drive Thousand Oaks, CA 91320-1799 805-447-1000</td>
</tr>
<tr>
<td>Plan Sponsor Employer Identification Number:</td>
<td>95-3540776</td>
</tr>
<tr>
<td>Claims Administrator Address:</td>
<td>Connect Your Care (“CYC”) 307 International Circle, Suite 200 Hunt Valley, MD 21030</td>
</tr>
<tr>
<td>Claims Administrator Telephone:</td>
<td>800-972-6436</td>
</tr>
<tr>
<td>Plan Number:</td>
<td>518</td>
</tr>
<tr>
<td>Plan Year:</td>
<td>January 1 – December 31</td>
</tr>
<tr>
<td>Type of Plan:</td>
<td>This Plan is a welfare plan.</td>
</tr>
<tr>
<td>Type of Funding:</td>
<td>The Employer-paid portion of the Plan is intended to be an unfunded “health reimbursement arrangement” as defined under IRS Notice 2002-45. The Participant-paid portion of the Plan is funded through a trust that is intended to be a “voluntary employees’ beneficiary association” as defined in Section 501(c)(9) of the Internal Revenue Code.</td>
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<tr>
<td>Trustee:</td>
<td>Merrill Lynch Bank &amp; Trust Co.</td>
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<td>Type of Administration:</td>
<td>Records are maintained by the Plan’s third party administrators, including CYC (claims) and Merrill Lynch (enrollment and Accounts).</td>
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<td>Agent for Service of Legal Process:</td>
<td>General Counsel Amgen Inc. One Amgen Center Drive Thousand Oaks, CA 91320-1799 805-447-1000</td>
</tr>
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<td>Requests for Information:</td>
<td>If you have any questions regarding your benefits, please contact the Amgen Benefits Center at (800) 97 AMGEN</td>
</tr>
<tr>
<td>Claims and appeals:</td>
<td>Should be in writing and sent by certified mail to the Claims Administrator.</td>
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DEFINED TERMS

Any term that begins herein with an initial capital letter shall have the special meaning defined in the Plan, unless the context clearly requires otherwise. Here are some key definitions that will help you better understand this summary of the Plan:

“Accounts” means your Employee Contributions Account, if any, your Employer Contributions Account, if any, and, when applicable, your COBRA Account.

“Authorized Leave of Absence” means any period of absence from service with Amgen authorized by Amgen under its applicable personnel practices (including any period required by the Uniform Services Employment and Reemployment Rights Act of 1994 or any period of absence covered by the Family and Medical Leave Act of 1993), paid holidays and paid vacation.

“Base Compensation” means base pay for exempt Eligible Employees, including pay for time lost due to jury duty, bereavement, or severe weather conditions. For non-exempt Eligible Employees, Base Compensation means base hourly rate plus overtime wages, payments for shift differentials and premiums and any payments for time lost due to jury duty, bereavement, or severe weather conditions.

“Beneficiary” means a Participant’s Spouse (or Domestic Partner) and/or Dependents who are designated, in such form and manner as required by the Plan Administrator after the Participant’s death as being eligible to obtain reimbursement of Eligible Medical Expenses from the Participant’s Accounts in the event of his or her death. If at any time, a Beneficiary who is a Dependent ceases to qualify as a Dependent, he or she will no longer be considered a Beneficiary (however, the former Beneficiary may be eligible for COBRA continuation coverage (see Q&As 33-39)).

“Bonus Compensation” means any commissions received by an Eligible Employee who is a salesperson and any cash bonuses paid to an Eligible Employee under the Employer's annual cash incentive bonus plans (the Amgen Inc. Executive Incentive Plan, the Global Management Incentive Plan, the Value Enhancement Program, and any similar or successor plans or programs).

“Break in Service” means any period of absence from active service with Amgen that is not an Authorized Leave of Absence.

“Claims Administrator” means the third party to whom the Plan Administrator delegates claims administration authority. Currently, the Claims Administrator is Connect Your Care.


“Covered Individual” means a Terminated or Retired Participant and his or her Dependents and Spouse or Domestic Partner. In addition, upon the death of a Participant, a Covered Individual will include any Beneficiary.
“Dependent” means any individual who is a “Dependent Child” or “Dependent Relative.” The determination of who qualifies as a Dependent will be made in the Plan Administrator’s sole discretion.

“Dependent Child” means a Retired or Terminated Participant’s child who has not attained age 26 or is your child, regardless of age, who is Permanently Disabled. An individual will be considered your child if he or she is your natural child, adopted child, child placed with you for adoption or stepchild or if you are responsible to provide medical coverage for the individual under a qualified medical child support order (QMCSO).

“Dependent Relative” means any of the following individuals, provided he or she receives over 50% of his or her financial support from you:

- your child (other than a Dependent Child) or a descendent of your child;
- your sibling or stepsibling;
- your parent, or an ancestor of your parent;
- your stepparent;
- your aunt, uncle, niece, or nephew;
- your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; and
- any other individual who, for the calendar year, uses your home as his or her principal place of abode and is a member of your household.

“Domestic Partner” means an individual for whom you have completed, in a manner satisfactory to the Plan Administrator, evidence of Domestic Partnership in accordance with procedures set forth by the Plan Administrator. (See Q&A 19 regarding limitations on Domestic Partner reimbursements under the Plan.)

“Effective Date” means July 1, 2009.

“Eligible Employee” means an individual who is a regular full-time or part-time staff member of Amgen and its designated affiliates and subsidiaries. Notwithstanding the foregoing, you are not an Eligible Employee if you are in any of the following excluded categories:

- you are an employee covered by a collective bargaining agreement that does not provide for eligibility to participate in the Plan;
- you are an individual from whom Amgen does not withhold federal income and employment taxes;
- you have an oral or written agreement that provides you are not eligible to participate in the Plan;
- you are employed by a non-US subsidiary (including Puerto Rico) of Amgen;
- you are a "leased employee" (within the meaning of Internal Revenue Code 414(n));
• you are not regularly scheduled to work at least 20 hours per week; or

• you are classified by Amgen as a temporary worker, intern, co-op, independent contractor, or consultant.

If you are classified as a “leased employee,” “temporary worker,” “intern,” “co-op,” “independent contractor,” or “consultant,” or similar classification by Amgen (which status may be evidenced by the payroll practices or records of Amgen, or by a written or oral agreement or arrangement with you or with another entity, under which you are treated as an independent contractor or as an employee of an entity other than Amgen (such as a leasing organization)), you are not eligible to participate in the Plan during the period so classified, irrespective of:

• whether you are considered an employee of Amgen under common law employment principles;

• whether such characterization is subsequently challenged, changed or upheld by Amgen or any court or governmental authority, including, without limitation, if you are classified by Amgen as a leased employee; and

• how you are treated by Amgen for other purposes (such as employment tax purposes).

“Eligible Medical Expenses” means expenses for medical care incurred by a Covered Individual that are described under the section entitled REIMBURSEMENT OF ELIGIBLE MEDICAL EXPENSES.

“Employee Contributions” means your after-tax contributions to the Plan, if any.

“Employer” or “Amgen” means Amgen Inc., Amgen USA Inc., Amgen Worldwide Services, Inc., BioVex, Inc., Immunex Corporation, Immunex Manufacturing Corporation, Immunex Rhode Island Corporation, Amgen SF, LLC, Amgen Fremont Inc., Amgen Rockville Inc., KAI Pharmaceuticals, Inc., the legal successor to any of the foregoing entities and any other entity that the Plan Administrator has designated in writing as an Employer.

“Employer Contributions” means the credits made by the Employer to the Employer Contributions Accounts, if any.

“FMLA” means the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave” means a leave of absence that the Employer is required to extend to an Eligible Employee under the provisions of the FMLA.

“HSA” means a Health Savings Account established under Section 223 of the Code.

“Participant” means an Eligible Employee who has either an Employee Contributions Account or an Employer Contributions Account (or both).

“Permanently Disabled” means unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. An individual shall not be considered to be Permanently Disabled unless he or she furnishes proof of the existence thereof in such form and manner, and at such time, as the Plan
Administrator may require and such disability is certified by the Plan Administrator or a third party acceptable to the Plan Administrator.

“Plan” means the Amgen Inc. Retiree Medical Savings Account Plan.

“Plan Administrator” means Amgen Inc.

“Plan Year” means each calendar year beginning on or after the Effective Date. The first Plan Year will be from the Effective Date until December 31, 2009.

“Primary Beneficiary” means the Beneficiary that has the sole ability to seek reimbursements from a deceased Participant’s Accounts on behalf of the deceased participant and on behalf of himself/herself and all other Beneficiaries.

“Release” means the general release of claims in the form provided by the Employer.

“Retired Participant” means a Participant who voluntarily terminates employment with the Employer (including any affiliates of the Employer) after (i) attaining at least age 55 with ten Years of Service, (ii) attaining at least age 65 or (iii) after incurring a Total Disability. A Participant who becomes eligible to receive severance benefits pursuant to a change of control severance plan sponsored by Amgen Inc., shall be treated as a Retired Participant (subject to satisfying the Release requirements below) to the extent such treatment does not create a material risk that the Plan would violate the prohibition on discrimination in Section 105(h) of the Code (or any similar provision of the Code or other applicable law), as determined the Plan Sponsor in its sole discretion. A Participant shall not become a Retired Participant until the Participant also executes a Release, which, among other things, acknowledges the requirements described under the section entitled REIMBURSEMENT OF ELIGIBLE MEDICAL EXPENSES and requires the Participant to release all claims he or she may have against Amgen. A Participant who would qualify as a Retired Participant but does not sign the Release shall be treated as a Terminated Participant.

“Spouse” means an individual who is legally married to you at the time you are a Terminated or Retired Participant or at the time of your death. A Spouse does not include an individual separated from the Terminated or Retired Participant under a legal separation decree.

“Terminated Participant” means a Participant who has terminated employment with the Employer (including any affiliates of the Employer) and does not qualify as a Retired Participant.

“Total Disability” means that a Participant is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. Such disability shall be certified prior to the Participant’s termination of employment from Amgen by the (i) the Social Security Administration, (ii) comparable
governmental authority applicable to an affiliate or subsidiary of Amgen, (iii) such other body having the relevant decision-making power applicable to a subsidiary or affiliate of Amgen, or (iv) an independent medical advisor appointed by the Plan Administrator in its sole discretion, as applicable, in any such case.

“Trust” means the Amgen Inc. Voluntary Employees’ Beneficiary Association Trust.


“Year of Service” means the period of three hundred sixty-five (365) calendar days during which the Employer employs the Eligible Employee. If an Eligible Employee’s employment with the Employer terminates and the Eligible Employee is subsequently rehired, the Eligible Employee’s Years of Service shall be determined by counting his or her pre-break service, but only if the Eligible Employee remains employed by Amgen for twelve consecutive calendar months upon being rehired.
PLAN ADMINISTRATION

Amgen is the “administrator” of the Plan and a “named fiduciary” within the meaning of such terms as used in the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). Amgen is the Plan’s agent for service of legal process. Amgen has the duty and authority to interpret and construe the Plan in regard to all questions of eligibility, the status and rights of any participant under the Plan, and the manner, time, and amount of payment of any benefits under the Plan.

The “fiduciary committee” is the “named fiduciary” for the purposes of selecting investment options offered under the Plan. The fiduciary committee may adopt rules with respect to the investment options offered under the Plan and has the sole discretion to interpret such rules.

Amgen may designate any entity or entities to carry out its duties and responsibilities as Plan Administrator. For example, Amgen has delegated authority to administer claims and appeals to the Claims Administrator. Amgen may adopt such rules and procedures as it deems desirable for the administration of the Plan.
PARTICIPANTS AND ELIGIBLE FAMILY MEMBERS

1. Am I Eligible to Participate?

You can participate in the Plan if you are an “Eligible Employee.” You will become a “Participant” in the Plan on the date that you first make an Employee Contribution or Amgen first credits an Employer Contribution for you to the Plan and the Plan Administrator establishes one or both of your Accounts.

2. What Does it Mean to be a “Participant”?

You are Participant if you have an Employee Contributions Account, Employer Contributions Account, or both. As a Participant, you can make voluntary after-tax contributions to your Employee Contributions Account (see the section below entitled EMPLOYEE AFTER-TAX CONTRIBUTIONS) and Amgen may credit notional amounts to your Employer Contributions Account (see the section below entitled EMPLOYER CONTRIBUTIONS).

Because the Plan is intended to assist in saving for your retiree medical needs, you will only be able to draw from your Accounts for the reimbursement of Eligible Medical Expenses when you become a Terminated Participant or Retired Participant.

3. Which of My Family Members Can Benefit Under the Plan?

When you become a Terminated or Retired Participant (discussed later in this SPD), you will be able to receive reimbursement for Eligible Medical Expenses incurred by any Covered Individual.

IMPORTANT: Upon your death, your Spouse (or Domestic Partner) and any eligible Dependents must contact the Plan Administrator and provide evidence within two years of your death, in such form as required by and satisfactory to the Plan Administrator, to be designated as Beneficiaries. If such individuals do not contact the Plan Administrator, or do not provide the information as required by the Plan Administrator, then such individuals will not be able to seek reimbursement for Eligible Medical Expenses.

4. What Happens to My Accounts if I Die?

If you die, your Beneficiaries will be eligible to obtain reimbursement of Eligible Medical Expenses from your Accounts according to the rules described below.

Within two years following your death, an individual who qualified as your Spouse (or Domestic Partner) or Dependent at the time of your death must contact the Plan Administrator and show valid evidence satisfactory to the Plan Administrator, that he or she qualified as a Spouse (or Domestic Partner) or Dependent on the date of your death. A legal guardian or another individual may contact the Plan Administrator and submit information on behalf of minor Dependents. Individuals who provide such information to the satisfaction of the Plan Administrator shall be designated as Beneficiaries.
The Plan Administrator will designate a Primary Beneficiary from the individuals who qualify as Beneficiaries, based on the evidence provided in accordance with the above paragraph. The Primary Beneficiary is the only Beneficiary who can submit claims for reimbursements from your Accounts and will be responsible for submitting claims for himself/herself and all other Beneficiaries. When choosing between multiple Beneficiaries, the Plan Administrator shall designate the Primary Beneficiary based on the following priority: (1) Spouse or Domestic Partner and (2) Dependent (eldest to youngest).

If the Plan Administrator designates someone other than your Spouse or Domestic Partner as the Primary Beneficiary, your Spouse or Domestic Partner may have the ability to become the Primary Beneficiary (in lieu of the designated Dependent Beneficiary) if he/she provides the required evidence to the Plan Administrator within the two year designation period. However, if a Dependent comes forward after the Primary Beneficiary is chosen, he or she will not become the Primary Beneficiary and may only obtain access to your account as a Beneficiary, if designated by the Plan Administrator.

For example, if the Plan Administrator designates your 18 year old Dependent as the Primary Beneficiary and six months later, your Spouse fulfills the procedure established by the Plan Administrator to prove his/her relationship to you, the Spouse shall become the Primary Beneficiary. However, if the second individual to come forward is instead your 21 year old Dependent, then no change in Beneficiary status will take place and such individual may only become a Beneficiary based on Plan Administrator approval.

If the Primary Beneficiary dies or becomes ineligible prior to the full distribution of the Accounts (e.g., Dependent attains age 26), then the remaining Beneficiary that has the highest priority (as determined above) becomes the Primary Beneficiary. This process shall continue until the earlier of (a) the depletion of your Accounts, or (b) there are no remaining eligible Beneficiaries.

IMPORTANT: If no valid individual comes forward within two years after your death and satisfies Beneficiary status, then both your Employee Contributions Account and Employer Contributions Account will be forfeited.
EMPLOYEE AFTER-TAX CONTRIBUTIONS

If you are an Eligible Employee, you may make contributions to the Plan on an after-tax basis. Any after-tax contributions that you make to the Plan will be allocated to your Employee Contributions Account, plus any investment gains and minus investment losses credited thereon while held in the Trust. In addition, COBRA premiums paid by your former Spouse, Domestic Partner or Dependent children who lose coverage and elect COBRA (pursuant to the COBRA CONTINUATION COVERAGE SECTION -- see Q&As 34-40 for details) will also be deposited to your Employee Contributions Account.

5. How do I Make Contributions to My Employee Contributions Account?

The way to make contributions to your Employee Contributions Account is by regular after-tax payroll deductions. You can elect an amount of contribution based on a percentage of your Base Compensation and Bonus Compensation, in specific multiples of one percent (1%), to the Plan from time to time through Benefits OnLine at www.benefits.ml.com.

Please keep in mind that the password you use to access Merrill Lynch Benefits Online can be used to access your personal account information and other accounts held with Merrill Lynch, so you should be sure to maintain the confidentiality of that information. Once you are no longer employed with Amgen, you should verify that your email address and permanent address on file are up to date, especially if you recently moved, were divorced or separated from your spouse. This is important to protect your privacy because Plan communications, including but not limited to, account statements, legally-required communications, confirmation statements and temporary password requests, may be mailed to the permanent address on file at the Plan.

6. Is there a Limit on the Amount of After-Tax Contributions I Can Make to My Employee Contributions Account?

Yes. You cannot contribute more than fifty percent (50%) of your Base Compensation and eighty percent (80%) of your Bonus Compensation. Note that your contributions are taken from your eligible compensation after certain other deductions are determined at the Plan Administrator’s discretion, including all contributions to the 401(k) plan (i.e., pre-tax, Roth, and after-tax), pre-tax premiums for the health plan, and pre-tax contributions to a flexible spending account.

IMPORTANT: Certain executive officers are considered “key employees” within the meaning of Code Section 416(i). You generally are a key employee if you are or have been one of the fifty (50) highest compensated officers of Amgen. If you are a key employee, Employee Contributions credited to your Employee Contributions Account will count as “annual additions” under Code Section 415, which imposes a cap on the total amount of employee and employer contributions that may be contributed to your account under the Amgen Retirement and Savings Plan (your 401(k) plan). For 2017, this limit is $54,000. You will be notified if you are a key employee.

7. What Are the Investment Options Available for My Employee Contributions Account?
Contributions are invested at your direction among the mutual funds offered under the Plan. Please see the chart below for the current investment options. You must make your investment elections based on whole percentages, not dollar amounts. These investment options are designed to meet the needs of a variety of investors. Detailed information about the investment options including prospectuses and information on how to change your investment direction is available on Benefits OnLine at www.benefits.ml.com or by calling the Amgen Benefits Center at 800-97-AMGEN (800-972-6436). Just as you review investments in your existing 401(k) and any other
savings accounts, you also should monitor your Employee Contribution Account investments and make changes when necessary. It is important to recognize that there are NO GUARANTEES of how your investments will do, and that past performance does not predict future performance. All of the investment alternatives offered have some risk, some more than others. Often those with the largest potential return have the greatest risk. Your ability and willingness to accept risk should be a very important factor in your investment decisions. This factor is influenced by your age and the length of time remaining before you terminate employment and when you plan to access your Accounts. How you spread your funds among the investment alternatives may also affect the risk of your investment decisions. The Fiduciary Committee at any time may determine to terminate the availability of any particular investment option or any of the investment alternatives or may choose to stop accepting future investment contributions. Should that occur, Participants will be notified. Information regarding the risk and return characteristics and other information regarding the investment alternatives under the Plan is available on Benefits OnLine at www.benefits.ml.com or by calling the Amgen Benefits Center at 800-97-AMGEN (800-972-6436). Please review each fund’s prospectus carefully before investing as it has important information regarding the fund’s investment objectives, risk and historical investment return characteristics, and the fees and expenses associated with an investment in the fund. Investing involves risk and may result in loss of principal.

A Word About Plan Fees

To further assist you in understanding how the Plan works, we have prepared the following overview of the components of Plan investment fees. The fees in the Plan can be broken down into two categories.

The first category is fees associated with Plan administration. This includes the things that need to be done to operate a plan on a day to day basis, such as recordkeeping, online access to participant accounts and voice access to customer service representatives. The Plan Administrator has negotiated with its service providers, Merrill Lynch, so that there are no separate charges to Participants for day-to-day Plan administration expenses.

The second and most important category is investment management and investment administration fees, which are the fees and expenses associated with managing an investment fund’s assets. It is important that you understand that Participants indirectly pay investment management fees and expenses with respect to all investment alternatives. These fees and expenses are paid out of the investment alternatives’ assets, thus reducing their returns. Custodial fees, if any, are paid by Amgen.

You can find information on the fees and expenses of these investment alternatives, as well as a description of them on Merrill Lynch Benefits Online.

You are encouraged to consult with a financial advisor to assess the investment opportunities contained in the Plan and to determine whether participation in the Plan is an appropriate investment alternative.
<table>
<thead>
<tr>
<th>Investment Option</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlackRock Liquidity Funds FedFund Institutional Share Class (as of September 1, 2016)</td>
<td>The FedFund seeks current income as is consistent with liquidity and stability of principal by investing as least 99.5% of its total assets in cash, U.S. Treasury bills, notes and other obligations issued or guaranteed as to principal and interest by the U.S. Government, its agencies, and repurchase agreement secured by such obligations or cash. The yield of the Fund is not directly tied to the federal funds rate. The Fund invests in securities maturing in 397 days or less (with certain exceptions) and the portfolio will have a dollar-weighted average maturity of 60-days or less and a dollar-weighted average life of 120 days or less. The Fund may invest in variable and floating rate instruments, and transact in securities on a when-issued, delayed delivery or forward commitment basis.</td>
</tr>
<tr>
<td>Vanguard Total Bond Market Index Institutional (as of August 24, 2012)</td>
<td>The fund seeks to track the performance of a broad, market-weighted bond index. The fund employs an indexing investment approach designed to track the performance of the Barclays Capital U.S. Aggregate Float Adjusted Index. It invests by sampling the index, meaning that it holds a broadly diversified collection of securities that, in the aggregate, approximates the full index in terms of key risk factors and other characteristics. The fund invests at least 80% of assets in bonds held in the index. It maintains a dollar-weighted average maturity consistent with that of the index, ranging between 5 and 10 years.</td>
</tr>
<tr>
<td>Vanguard Institutional Index Institutional (as of August 24, 2012)</td>
<td>The fund seeks to track the performance of a benchmark index that measures the investment return of large-capitalization stocks. The fund attempts to replicate the target index by investing all, or substantially all, of its assets in the stocks that make up the index, holding each stock in approximately the same proportion as its weighting in the index.</td>
</tr>
<tr>
<td>Vanguard Extended Market Index Institutional (as of August 24, 2012)</td>
<td>The fund seeks to track the performance of a benchmark index that measures the investment return of small- and mid-capitalization stocks. The fund employs an indexing investment approach designed to track the performance of the Standard &amp; Poor’s Completion Index, a broadly diversified index of stocks of small and mid-size U.S. companies. It invests all, or substantially all, of its assets in stocks of its target index, with nearly 80% of its assets invested in approximately 1,200 of the stocks in its target index, and the rest of its assets in a representative sample of the remaining stocks.</td>
</tr>
<tr>
<td>Dodge &amp; Cox International Stock Fund</td>
<td>The investment seeks long-term growth of principal and income. The fund invests primarily in a diversified portfolio of equity securities issued by non-U.S. companies from at least three different countries, including emerging markets. It normally invests at least 80% of its total assets in common stocks, preferred stocks, securities convertible into common stocks, and securities that carry the right to buy common stocks of non-U.S. companies. The fund invests primarily in medium- to-large well established companies based on standards of the applicable market.</td>
</tr>
</tbody>
</table>
You should carefully read the various prospectuses (as applicable) for each of the investment funds and other materials provided on Merrill Lynch Benefits Online at www.benefits.ml.com.
Providing an investment direction is an integral part of enrolling in the Plan. Your application for enrollment will be considered incomplete until you provide an investment direction for all of your Employee Contributions Account.

Your Employee Contributions Account balance will be increased or decreased for the gains or losses resulting from your investment direction as well as for any required administrative expenses.

8. **When Can I Use Amounts in My Employee Contributions Account?**

Starting on the date that you become a Terminated or Retired Participant, your Employee Contributions Account balance will be available to you to reimburse the Eligible Medical Expenses incurred by you and your Spouse (or Domestic Partner) and Dependents on a tax-free basis. However, no reimbursement shall be paid unless you submit a claim for reimbursement of Eligible Medical Expenses, as outlined in Q&As 23-24. See Q&A 20 for further details on Eligible Medical Expenses.

9. **For How Long Can I Make Employee Contributions?**

You will no longer be eligible to make Employee Contributions upon the earlier of the following:

- the date you cease to be an Eligible Employee;
- the date you cease receiving Base or Bonus Compensation through an Employer payroll;
- the date you fail to return to active employment with Amgen at the end of an Authorized Leave of Absence or, while on such leave of absence, you give notice to Amgen that you do not intend to return to active employment;
- the date you die; or
- the date Amgen terminates the Plan or amends the Plan to cease your ability to make future Employee Contributions.

If you are on an Authorized Leave of Absence and otherwise eligible to contribute to the Plan, you may make Employee Contributions if your authorized leave of absence is (1) paid, or (2) unpaid and applicable law requires that you remain eligible to make Employee Contributions.

10. **What Happens to My Employee Contributions Account if I Die?**

If you die, your Beneficiaries will obtain access to your Employee Contributions Account for their Eligible Medical Expenses. (See Q&A 4 for further details regarding Beneficiaries’ access to your Accounts.)

If you do not have any Beneficiaries when you die or all of your Beneficiaries become ineligible, the entire remaining balance of your Employee Contributions Account will be forfeited to the Plan. At the discretion of the Plan Administrator, any amounts forfeited to the Plan may be used to pay reasonable Plan expenses or may be reallocated to the Employee Contributions Accounts of all other Participants in an equal amount per Participant.
11. **What Happens if I Go On an FMLA Leave or I Leave for Duty in the Uniformed Services as Covered in USERRA?**

If you go on an FMLA Leave or leave for duty in the Uniformed Services covered by USERRA, then to the extent required by FMLA or USERRA, as applicable, Amgen will continue to maintain your Employee Contributions Account on the same terms and conditions as if you were still an Eligible Employee.
EMPLOYER CREDITS

12. **How Much Will Amgen Contribute to My Employer Contributions Account?**

Amgen will credit each Eligible Employee with (i) an initial base credit of $5,000 upon the Effective Date of the Plan, (ii) an annual base credit of $1,000 at the end of each Plan Year, (iii) a matching credit equal to 50% of your Employee Contributions up to a maximum of $1,500 per Plan Year, credited on a payroll basis; (iv) any investment gains (as outlined below); and (v) any premiums paid for COBRA coverage under your Employer Contributions Account pursuant to the COBRA CONTINUATION COVERAGE section in Q&As 33-39. See Q&A 14 for information on when you are entitled to these amounts.

In order to receive the initial base credit under (i) above, you must have been an Eligible Employee on the Effective Date. In order to receive the annual base credit under (ii) above, you must be an Eligible Employee on Amgen’s last business day of the Plan Year. This annual base credit will be credited in full, and will not be prorated for partial years if you become employed after the beginning of the Plan Year. Employer Contribution Accounts are unfunded notional accounts that are credited directly from Amgen’s general assets and not set aside in trust or otherwise funded in any way. Your rights to Employer Contribution Accounts are no greater than a general creditor of Amgen and may not be transferred, assigned or alienated in any way.

13. **How Will Investment Gains or Losses Affect My Account?**

Amgen may, in its sole discretion, credit or debit your Employer Contributions Account with any investment gains or losses based on investment media selected by Amgen. The investment media may include an index, fund, or any fixed return (“Measurement Fund”). Amgen may, in its sole discretion, discontinue, substitute or add a Measurement Fund or cease crediting investment returns altogether. Currently, Employer Contributions are credited with interest on a daily basis based on an annual rate of return equal to 2.75%. This rate remains subject to change at any time.

The Measurement Funds are to be used for measurement purposes only, and the Employer’s use of any such Measurement Fund, the calculation of additional amounts and the crediting or debiting of such amounts to an Employer Contribution Account shall not be considered or construed in any manner as an actual investment in any such Measurement Fund.

14. **When Can I Use Amounts in My Employer Contributions Account?**

Starting on the date that you voluntarily terminate employment with Amgen after (i) attaining at least age 55 with ten Years of Service, (ii) attaining at least age 65 or (iii) after incurring a Total Disability, you will have the option of signing a Release provided by Amgen, which will allow you to access your Employer Contributions Account for Eligible Medical Expenses.

If you decide not to sign the Release, you will still have access to your Employee Contributions Account and will be able to use the funds in your Employee Contributions Account to obtain reimbursement for any Eligible Medical Expenses; however, you will not be able to use any
funds from your Employer Contributions Account. See Q&A 20 for further details on Eligible Medical Expenses.

15. **What Happens to My Employer Contributions Account if I Leave Amgen Before I am Eligible to Retire?**

If you terminate from Amgen before you are eligible to “retire” (i.e. before attaining at least age 55 with ten or more Years of Service or after attaining at least age 65), or if you terminate and are eligible to retire but do not sign the Release, you will forfeit your Employer Contributions Account on the date of such termination.

16. **What Happens to My Employer Contributions Account if I Die?**

If you die while you are still employed with Amgen, regardless of whether or not you are eligible to “retire” (i.e. terminating employment after having attained at least age 55 with ten or more Years of Service or after having attained at least age 65), your Beneficiaries will obtain access to your entire Employer Contributions Account for their Eligible Medical Expenses. Also, if you are a Retired Participant and die, your Employer Contributions Account will remain available for reimbursement of Eligible Medical Expenses incurred by your Beneficiaries. (See Q&A 4 for further details regarding Beneficiaries’ access to your Accounts.)

If you do not have any Beneficiaries when you die or all of your Beneficiaries become ineligible, the entire remaining balance of your Employer Contributions Account will be forfeited.

Note that regardless of what is stated immediately above, per IRS rules, there are special considerations for Beneficiaries who are Domestic Partners. Unless your Domestic Partner also qualifies as a Dependent Relative, your Domestic Partner may not receive reimbursements from your Employer Contributions Account. This means that if you die and your only Beneficiary is your Domestic Partner, your Employer Contributions Account will be forfeited if your Domestic Partner does not qualify as a Dependent Relative.

Note that if you are a Terminated Participant when you die, your Employer Contributions Account remains forfeited.

17. **What Happens If I Go On an FMLA Leave or I Leave for Duty in the Uniformed Services as Covered by USERRA?**

If you go on an FMLA Leave or leave for duty in the Uniformed Services covered by USERRA, then to the extent required by FMLA or USERRA, as applicable, Amgen will continue to maintain your Employer Contributions Account on the same terms and conditions as if you were still an active Eligible Employee.
18. What Happens if I am Rehired by Amgen After a Break in Service?

If you are rehired after a Break in Service, you may receive credit for prior Years of Service for purposes of retirement eligibility. Your Employer Contributions Account that you accrued during your prior employment with Amgen will be reinstated upon your completion of 12 months of service from your date of rehire.

19. May I Receive Reimbursements from My Employer Contributions Account for Eligible Medical Expenses Incurred by My Domestic Partner?

Per IRS rules, Eligible Medical Expenses incurred by Domestic Partners may not be reimbursed from your Employer Contributions Account unless your Domestic Partner qualifies as your Dependent Relative. See Q&A 20 for further details on Eligible Medical Expenses.
REIMBURSEMENT OF ELIGIBLE MEDICAL EXPENSES

20. What is an Eligible Medical Expense?

Eligible Medical Expenses are those expenses incurred by a Covered Individual for “medical care” as defined in Code Section 213(d). You may find a general overview of the types of expenses that would qualify as being for medical care in IRS Publication 502 (Medical and Dental Expenses) on the IRS web site: www.irs.gov. Note that expenses incurred for medicines or drugs are Eligible Medical Expenses only if the medicine or drug (1) requires a prescription, (2) is available without a prescription (an over-the-counter medicine or drug) and you obtain a prescription, or (3) is insulin.

Eligible Medical Expenses shall include charges for services or supplies for the following treatments for a Covered Individual who had a mastectomy while covered by the Plan: (a) all stages of reconstruction of the breast on which the mastectomy has been performed, (b) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (c) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician of the Covered Individual.

If you are a Retired Participant and you or your Spouse or Domestic Partner are not eligible for Medicare, then Eligible Medical Expenses shall be limited to premiums for healthcare coverage obtained from sources other than Amgen including, for example, the Health Insurance Marketplace under the Affordable Care Act (“Marketplace”). However, you may not use your RMSA Account assets if you are receiving health coverage from another employer and the premiums for that coverage are paid with pre-tax dollars. The limitation requiring you to use RMSA Account funds for premiums for medical coverage will no longer apply when you and your Spouse or Domestic Partner are both eligible for Medicare. It is important to note that you may be ineligible for a Federal Premium Tax Credits if you use your RMSA Account funds to pay for coverage through the Marketplace.

If you are the Primary Beneficiary of a deceased Participant who either (1) died while in active employment with Amgen or (2) was a Retired Participant and died before his or her Employer Contributions Account was fully depleted, and you are not eligible for Medicare, then Eligible Medical Expenses for you and all Beneficiaries shall be limited to medical coverage premiums, Medicare premiums and premiums for health insurance that is supplemental to Medicare. This limitation will no longer apply when you become eligible for Medicare.

IMPORTANT: Per IRS rules, Eligible Medical Expenses incurred by Domestic Partners who do not qualify as Dependent Relatives may be reimbursed only from Employee Contributions Accounts, subject to certain limits. Please refer to the Plan or contact the Claims Administrator for more information.

21. What are Not Considered Eligible Medical Expenses?

The following shall not be considered Eligible Medical Expenses: (a) any prescription drug obtained outside of the United States that is consumed in the United States but not legally imported, or a drug that is consumed outside of the United States and is not legal in the United
States or the applicable country; (b) expenses (not including premiums) for qualified long-term care services as defined by applicable IRS rules; (c) expenses for which you have been reimbursed or for which you will seek reimbursement under any other insurance, accident, or health plan; (d) COBRA premiums paid for the continuation of this Plan as described in the section COBRA CONTINUATION COVERAGE; and (e) any expense the reimbursement of which might, in the Plan Administrator’s sole discretion, jeopardize the intended tax status of the Plan, the Trust or Plan reimbursements.

**IMPORTANT:** If you are eligible for a Health FSA, you may not use your Accounts for expenses that are reimbursable under an available Health FSA until you have received the maximum amount available in your Health FSA account for the year. The Plan Administrator may require Participants to certify that they will not seek reimbursements from the Plan until their Health FSA balance is zero.

For example, if you have a Health FSA election of $100 for the year, you may not claim expenses that could be reimbursed through the Health FSA until your Health FSA account is depleted.

22. **When Can I be Reimbursed for Eligible Medical Expenses from My Accounts?**

**Employee Contributions Account:** You are eligible to be reimbursed for Eligible Medical Expenses using amounts from your Employee Contributions Account starting on the date that you become a Terminated or Retired Participant (or Beneficiary, as applicable). See Q&A 20 for further details on Eligible Medical Expenses.

**Employer Contributions Account:** You are eligible to be reimbursed for Eligible Medical Expenses using amounts from your Employer Contributions Account starting on the date that you become a Retired Participant (or Beneficiary, as applicable). See Q&A 20 for further details on Eligible Medical Expenses.

It is important to note that you may not receive reimbursements from your RMSA Plan Accounts if you contribute to a HSA until you have met your High Deductible Health Plan’s annual deductible. Once the deductible has been met, you can receive reimbursements from the RMSA. It is your responsibility to ensure that you notify the Plan Administrator of your participation in a HSA and High Deductible Health Plan.

23. **How Am I Reimbursed for Eligible Medical Expenses?**

To be reimbursed you must deliver a written claim to the Claims Administrator in the form and medium, which may include electronic media, specified by the Claims Administrator. In addition, the Claims Administrator may require the following information:

- the person or persons on whose behalf Eligible Medical Expenses were incurred;
- the nature and date of the Eligible Medical Expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such expenses have not been reimbursed, are not reimbursable under a Health FSA, and that the Terminated or Retired Participant will not seek reimbursement through any other source;
• bills, invoices, receipts or other statements from an independent third party (e.g., a hospital, physician or pharmacy) showing that the Eligible Medical Expenses have been incurred and the amounts of such Eligible Medical Expenses; and
• any additional documentation that the Claims Administrator may request.

24. **When Must I Submit the Claim?**

There is no deadline for submitting a claim unless your Accounts equal less than $1,000. See Questions 28 for more information. All claims for reimbursement of Eligible Medical Expenses should be directed to the Claims Administrator.

25. **How Long Do I Have to Cash a Check Issued For Payment of Benefits Under the Plan?**

You must present for payment any check issued for payment of benefits within one year of the date of issue. If any check for benefits payable under the Plan is not presented for payment within one year of the date of issue, the Plan shall have no liability for the benefits payment and the amount of the check shall be forfeited.

26. **How Am I Reimbursed if I Have Both An Employee Contributions Account and An Employer Contributions Account?**

If you are a Retired Participant and you have both an Employer Contributions Account and an Employee Contributions Account, Eligible Medical Expenses will be reimbursed from your Accounts in proportion to the Account balances.

27. **How Are My Investments in the Employee Contributions Account Liquidated to Fund the Reimbursement?**

All claims will be paid proportionately from a Terminated or Retired Participant’s Employee and Employer Contributions Account. For the portion of the claim that will be paid from your Employee Contributions Account, each investment fund (including any cash investment) shall be sold on a proportionate basis to fund the reimbursement.

28. **When Does My Right to Reimbursement of Eligible Medical Expenses Cease?**

If you are a Terminated or Retired Participant, you will cease to be eligible for reimbursement of Eligible Medical Expenses from your Accounts upon the earliest of the following:

• when your Accounts are fully depleted through the reimbursement of Eligible Medical Expenses;

• with respect to reimbursement of Eligible Medical Expenses attributable to Employer Contributions, when the Plan is terminated;

• if the aggregate sum of your Accounts equal less than $1,000 on the last day of the Plan Year ("Valuation Date"), then you will only be permitted to request reimbursements under the Plan until the last day of the following Plan Year ("Determination Date"). After the Determination Date, any unused amounts remaining in your Accounts will be forfeited. Any earnings or contributions made to the Accounts that result in the aggregate sum of your Accounts equaling or exceeding $1,000 after the Valuation Date will not extend the time in which you may submit reimbursements past the Determination Date;
• you are rehired as an Eligible Employee. However, a rehired Eligible Employee who is a Participant may be eligible to make Employee Contributions and receive Employer Contributions, despite being ineligible for reimbursement of Eligible Medical Expenses. Please note that a rehired Terminated Participant will have his or her Employer Contributions Account reinstated upon his or her completion of 12 months of Amgen service from the date of rehire (see Q&A 18).

If you are a Beneficiary, you will cease to be eligible for reimbursement of Eligible Medical Expenses from the deceased Participant’s Accounts upon the earliest of the following:

• if a child dependent Beneficiary, the date on which such Beneficiary reaches age 26;

• when the deceased Participant’s Accounts are fully depleted through the reimbursement of Eligible Medical Expenses;

• with respect to reimbursement of Eligible Medical Expenses attributable to Employer Contributions, when the Plan is terminated;

• if the aggregate sum of the deceased Participant’s Accounts equal less than $1,000 on the last day of the Plan Year in which the Primary Beneficiary is designated by the Plan Administrator (“Valuation Date”), then the Primary Beneficiary will only be permitted to request reimbursements under the Plan until the last day of the Plan Year following such Valuation Date (“Determination Date”). After the Determination Date, any unused amounts remaining in the deceased Participant’s Accounts will be forfeited. Any earnings made to the Accounts that result in the aggregate sum of the deceased Participant’s Accounts equaling or exceeding $1,000 after the Valuation Date will not extend the time in which the Primary Beneficiary may submit reimbursements past the Determination Date.

29. **How Long Will it Take to Determine Whether My Claimed Medical Expense is an Eligible Medical Expense?**

The Claims Administrator will determine whether your claimed expense is an Eligible Medical Expense. If so, you will be reimbursed. If your claimed expense does not qualify as an Eligible Medical Expense, you will be notified within 30 days of the Claims Administrator’s receipt of your claim. However, if special circumstances require a 15-day extension of time to review your claim, you will be notified, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 30-day period. If the Claims Administrator requires additional information from you to decide the claim, you will be given at least 45 days to provide the required information. The deadline for making a determination of your claim will then be extended for 45 days or, if shorter, the length of time it takes you to provide the information.

30. **How Will I Be Notified if My Claim is Denied?**

The Claims Administrator will provide written notification of any claim denial. The notice will state:

• the reason for the decision;

• reference to the specific Plan provisions on which the decision was based;
• if the denial was based on an internal rule, guideline, protocol, or other similar criterion, a copy of it or a statement that it will be provided to you free of charge on request;
• a description of any additional information needed to support the claim and an explanation of why that information is necessary;
• a description of the Plan's review (i.e., appeal) procedures and the time limits applicable to such procedures; and
• information concerning your right to bring a civil action under section 502 of ERISA following a denial on review.

31. Can I Appeal an Adverse Benefit Determination?

Yes. When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision (for a claim for reimbursement of Eligible Medical Expenses) or 60 days (for other claims) following the receipt of the denial, or, if earlier, within 180 or 60 days, as applicable, after the claim should have been decided. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

32. Who Will Conduct the Review?

The decision on review will be conducted by the Claims Administrator personnel who did not decide the initial claim and who are not their subordinates. The reviewers will not afford deference to the initial adverse benefit determination. They will take into account all information that you presented in support of the appeal, including information not presented in connection with the initial claim. They will base their decision on input from a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment if the review would be decided in whole or in part on a medical judgment. The health care professional they consult will not be the same one utilized at the initial claim review stage or his or her subordinate.

33. What Happens if The Appeal is Denied?

If your appeal is denied, you will be sent written notice of the denial, including the following:
• the reasons for the decision;
• reference to the Plan provisions on which the decision is based;
• if the reason for the denial is an internal rule, protocol, guideline, or other similar criterion, a copy of it or a statement that it will be provided to you free of charge on request;
• a statement that you are entitled to receive, on request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
- information concerning your right to bring a civil action for benefits under ERISA Section 502(a) and the following legally-required statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”
COBRA CONTINUATION COVERAGE

34. What is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of health care coverage for a “qualified beneficiary” who would otherwise lose coverage due to a “qualifying event.” The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”).

35. How Does COBRA Apply to this Plan?

Under the Plan, Participants are not eligible for benefits and do not have coverage under the Plan until they become either Terminated Participants or Retired Participants. In addition, individuals who are Spouses, Dependents or Domestic Partners of a Participant are not entitled to COBRA continuation coverage if they are not Covered Individuals under the Plan.

Participants who cease to be Eligible Employees do not lose coverage under the Plan and are, therefore, not qualified beneficiaries entitled to COBRA continuation coverage on account of a termination of employment or reduction in hours. Similarly, Covered Individuals who are Spouses, Dependents or Domestic Partners of a Participant, who may still seek reimbursement for Eligible Medical Expenses following a Participant’s death as Beneficiaries, do not lose coverage under the Plan and are, therefore, not qualified beneficiaries entitled to COBRA continuation coverage under any circumstances.

36. When is COBRA Coverage Provided?

If coverage for your Spouse or Dependent child would terminate due to any of the following “Qualifying Events”: (1) your death; (2) your divorce or legal separation; or (3) your Dependent Child ceasing to be a Dependent, your Spouse and/or Dependent Child may elect to continue his or her own coverage, provided they notify the Claims Administrator within 60 days after the “qualifying event” occurs or the date your Spouse and/or Dependent Child would otherwise lose coverage under the Plan due to a qualifying event, which is later, by calling 1-800-97AMGEN (1-800-972-6436), faxing written notice to 206 299 3158, or sending written notice to:

Benefits Service Center
PO Box 91109
Seattle, WA 98111-9209

Written notice must include the date and type of qualifying event and name of each Dependent Child and Spouse affected by the qualifying event. Additional information such as address and contact information must also be included.

If you or your Spouse or Dependent Children do not provide written notice to the Claims Administrator within 60 days after the qualifying event occurs or the date your Spouse and/or Dependent Child would otherwise lose coverage under the Plan due to a qualifying event, any
Spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage under COBRA.

A Domestic Partner who does not qualify as your Dependent does not have a right to continuation coverage under COBRA. However, the Plan currently provides Domestic Partners with an opportunity to elect continuation coverage on the same basis as Spouses under COBRA. The Employer retains the right to cease providing continuation coverage to Domestic Partners, in its sole discretion, in the future.

37. How Long Does the Continuation Coverage Last?

The maximum period of continuation coverage is 36 months, beginning on the first day of the month following the qualifying event.

38. Is There a Limit On the Amount of Eligible Medical Expenses for which a Covered Individual Can Request Reimbursement?

Yes. All Covered Individuals, in the aggregate, who are eligible to elect to COBRA continuation coverage and do so shall have the right to submit claims for Eligible Medical Expenses for up to one-half of the value of the Accounts as determined on the date of the first qualifying event listed in the subsection above entitled WHEN IS COBRA COVERAGE PROVIDED (“COBRA Account”).

The value of the COBRA Account shall be reduced by any investment losses, administrative expenses, and reimbursements of Eligible Medical Expenses. Thereafter, if a subsequent qualifying event results in additional COBRA Beneficiaries, then such new COBRA Beneficiaries shall share access to the remainder of the COBRA Account.

Once the COBRA Account has a value of $0, then, thereafter upon a subsequent qualifying event, a new COBRA Account shall be established equal to one-half on the value of the Accounts as determined on the date of such qualifying event. The COBRA Account shall be reduced and additional COBRA Beneficiaries shall be treated in accordance with the above paragraph.

If coverage terminates for all COBRA Beneficiaries and there are funds remaining in the COBRA Account, such funds shall revert back to the Accounts on a pro rata basis.

39. What if My Address Changes?

In order to protect your family’s rights, you should keep the Plan Administrator and Merrill Lynch 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, Merrill Lynch, or CYC, as applicable.

40. What if I Have Questions?

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest regional or district office of the U.S. Department of
Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA’s website at www.dol.gov/ebsa.
ERISA Rights

41. **What are My Rights Under ERISA?**

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that you are entitled to:

- examine, without charge, at the Plan Administrator’s office and at certain other locations, such as work sites, all plan documents including insurance contracts, collective bargaining agreements 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 Pension and Welfare Benefits Administration;

- obtain, upon written request to the Plan Administrator, copies of all plan documents governing the operation of the plan, including copies of the latest annual report (Form 5500 series), collective bargaining agreements and updated summary plan descriptions, and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;

- obtain, upon written request to the Plan Administrator, information as to whether a particular employer or employer organization is a sponsor of the plan and the address of any employer or employer organization that is a plan sponsor. Your beneficiaries also have a right to obtain this information upon written request to the Plan Administrator; and

- receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

**Continued Group Health Plan Coverage**

You may continue health care coverage if there is a loss of coverage under the plan as a result of a qualifying event. If you elect to continue coverage under this plan, you will need to continue contributing to the plan. Refer to the section entitled COBRA CONTINUATION COVERAGE for more information on continued coverage under COBRA.

**Prudent Actions by Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the persons who are responsible for the operation of the staff member benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in your interest and the interest of other plan participants and beneficiaries.

**Enforce Your Rights**

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 benefits is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relative to the decision (with no charge) and to appeal any denial, all within certain time schedules. You have the right to have the Amgen review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court (unless you have entered into a contract specifying arbitration as the forum for resolving disputes). In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per 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. In addition, if you disagree with the plan’s decision or lack of one concerning the qualified status of a Domestic Relations Order or a Medical Child Support Order, you may file suit in 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 (unless you have entered into a contract specifying arbitration as the forum for resolving disputes). 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.

**Assistance with Questions**

If you have any questions about your plan, you should contact the Plan Administrator in Thousand Oaks, California at the previously mentioned address.

If you have any questions or need assistance about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your 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.

**Future of the Plan**

Amgen intends to continue the Plan indefinitely but reserves the right to change, amend, or terminate the Plan at any time.