SHAKE SHACK

2026 BENEFITS GUIDE

HOURLY TEAM MEMBERS

YOUR WELL BEING MATTERS.

At Shake Shack, the first table we set is with you by putting our people first. Guided by our Shack Pact, we make decisions that reflect care, respect, and opportunity for every Team Member.

Our Commitment to You

We are proud to offer a strong and stable benefits program that supports your health, financial security, and peace of mind. Our medical plan options provide flexibility and choice so you can select the coverage that best fits your life. You also have access to dental, vision, life, and disability coverage, many of which are fully funded by Shake Shack for eligible Team Members. Our 401(k) Plan, with a match from Shake Shack, helps you build a solid foundation for your financial future.

Staying Balanced

The Open Enrollment period gives us a chance to pause, review our benefits, and ensure they continue to meet your needs while reaffirming our commitment to the well-being of you and your loved ones. Each year, we carefully review our benefits to ensure they remain competitive and sustainable. Like most employers, we occasionally experience changes in healthcare costs driven by national market trends such as higher provider and prescription expenses. When adjustments are needed, we work hard to keep any increases as modest as possible while maintaining the quality, choice, and flexibility that make our program competitive within our industry.

Making the Most of Your Benefits

This guide outlines everything you need to make informed choices about your benefits. Take time to review your current coverage, compare plan options, and use the tools and support available to you. If you have questions or need assistance, please reach out to our Benefits Team at benefits@shakeshack.com.

Thank You

We are grateful for all that you do to live out our mission and Stand for Something Good in our restaurants, with our guests, and in our communities. Thank you for being part of the Shake Shack team and for taking an active role in caring for your health and well-being.

With care and gratitude,

Jamie Griffin
Chief People Officer

Here's where to find ...

Shake Shack appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

This guide is intended to provide you an overview of the 2026 Shake Shack Benefits plans offered to all eligible Team Members. It has a summary of your plan options to help you select the benefit plan that suits you and/or your eligible dependents.

Shake Shack offers inclusive, comprehensive health benefits that support all Team Members and their families, regardless of gender, identity or community.

CONTACTS

Coverage	Contact	Phone	Website
Medical & Pharmacy	UnitedHealthcare	866.414.1959	myuhc.com
Dental	Cigna	800.244.6224	cigna.com
Vision	EyeMed	866.939.3633	eyemed.com
Flexible Spending Accounts (FSA) and Health Savings Account (HSA)	WEX	866.451.3399	wexinc.com
Life, AD&D and Disability	Lincoln Financial	800.487.1485	lfg.com
401(k) Retirement	Fidelity	800.343.3548	netbenefits.com
Employee Assistance Program	Guidance Resources	833.475.0980	GuidanceResources.com Username: LFGNY | Password: LFGNY1
Corporate Discounts	PerkSpot	-	shakeshack.perkspot.com
Benefit Questions	Benefits Team	646.844.6496	benefits@shakeshack.com

BENEFIT ELIGIBILITY

Support Center, Salaried Team Members, and CA Non-Exempt Managers are eligible for coverage on the 90th day following date of hire.

When To Enroll

- Annual Open Enrollment: October 27 — November 17, 2025 (For coverage effective January 1, 2026).
- New hires will be able to enroll starting the 45th day of employment and must enroll by the 89th day in order for coverage to be effective on your 90th day.
- Team Members must enroll within 30 days of experiencing a qualifying event (QLE).

Dependents

Eligible dependents for benefits plans include:

- Legal spouse or Domestic Partner of any gender identity (you must complete a **Domestic Partner Affidavit Form**)
- Children
  - Biological
  - Adopted
  - Domestic partner's children (with a completed Domestic Partner Affidavit Form)
  - Any child you support who lives with you in a parent-child relationship and for whom you are the legal guardian*
  - Children with disabilities of any age who are (or become) physically or mentally incapable of self-support while covered by Shake Shack's Team Member benefits program.

Qualifying Life Events (QLE)

It is your responsibility to notify People Resources Benefits Team at **benefits@shakeshack.com** within 30 days of the qualifying life event. Failure to do so may result in an inability to change your benefit election(s).

Here are some examples of qualifying life events:

- Birth, legal adoption or placement for adoption
- Marriage, divorce or legal separation
- Dependent child reaches age 26
- Spouse or dependent loses or gains coverage elsewhere
- Death of your spouse or dependent child
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or the state children's health insurance program
- Change in residence that changes coverage eligibility
- Court-ordered change
- Spouse's open enrollment that occurs at a different time than yours

Important

For medical, dental and vision benefits, you can cover children from birth to the end of the month in which they turn 26 years old.

Legal guardianship is established by the court, whereby a minor child is placed under the supervision of a guardian who, under the terms of the legal guardianship, is legally responsible for the care and custody of the child. It allows the guardian to access services for the child, something that would not be possible without the legal guardianship status.

ENROLLING IN BENEFITS

Follow these steps to enroll in your benefits:

1. **Log into Workday**
   Visit **myworkday.com**. Navigate to the enrollment event in your Workday tasks on the left-hand side of the page or the icon on the top right.

2. **Workday Task Notification**
   Team Members will receive a Workday Task email with direct link upon eligibility to enroll.

3. **Start Benefit Enrollment**
   Select plans under which you'd like to be covered.

4. **Verify Your Enrollment**
   Verify contact information, enter dependent(s)* and beneficiary(ies), and enroll or decline coverage for each benefit plan.

5. **Submit Your Enrollment**
   Complete enrollment and submit

***Dependents will require proof of dependency to be added to the plan**

For additional assistance, please contact Benefits@shakeshack.com with your questions.

Important

You **must** log into Workday when you become eligible for coverage. If you choose not to enroll, please waive coverage.

Annual Enrollment: Team Members will receive a direct link and Workday task notification in their email to enroll from October 27th through November 17th.

New Hires: Team Members will receive a direct link and Workday task notification on their 45th day to enroll in benefits to be effective their 90th day of employment.

STAY AHEAD WITH PREVENTIVE CARE!

Preventive care is one of the best ways to protect your health and avoid unexpected costs. When you make time for an annual check-in, you're taking control of your wellbeing and making the most of your benefits.

If you are covered under one of Shake Shack's medical plans, the in-network preventive care is FREE! Annual physical and preventive exams and screenings help identify health risks early on. Preventive care keeps you healthy and helps keep out-of- pocket medical expenses low.

INTRO TO MEDICAL PLAN OPTIONS

Shake Shack offers three (3) PPO plans with copays and one (1) high-deductible health plan (HDHP) that can be paired with a Health Savings Account (HSA). Learn more about HSAs on page 8.

All four (4) UHC medical plans have in- and out-of-network coverage, cover the same medical services, and cover preventive care at no out-of-pocket cost to you if enrolled. To maximize your benefits and save on costs, be sure to visit providers and facilities in the UHC Choice Plus network.

Please click the **Decision Tool Guide** to view examples of how much the medical plans may cost based on your enrollment and coverage level selection in one of the four plans offered.

The descriptions below are meant to help you choose the plan that makes the most sense for you and your family.

High Deductible Health Plan with HSA

- Affordable premiums
- Value shoppers
- Generally healthy, low utilizers
- Financially-strategic members who wish to minimize taxable income
- Members willing to take on the risk of a higher deductible and no first dollar coverage

Basic Plan

- Affordable premiums
- More risk averse – copays for frequent services, but high deductible
- Those that just want coverage for cheapest possible premium

Plus Plan

- Risk-averse members that want substantial coverage
- Cost-conscious but willing to pay for comfort of richer plan
- Moderate utilizers

Premier Plan

- Risk-averse members that want substantial coverage
- Will pay any cost in order to have the richest plan
- Heavy utilizers

MEDICAL AND RX PLAN BENEFITS

United Healthcare

UnitedHealthcare | myuhc.com | 866.414.1959

Medical	HDHP with HSA		Basic Plan		Plus Plan		Premier Plan	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Deductible Individual Family	 $3,400 $6,800	 $6,800 $13,600	 $5,000 $10,000	 $10,000 $20,000	 $2,000 $4,000	 $3,000 $6,000	 $750 $1,500	 $1,500 $3,000
Coinsurance	30%	50%	50%	50%	20%	50%	10%	50%
Out-of-pocket max. (includes deductible) Individual Family	 $6,800 $13,600	 $13,600 $27,200	 $9,200 $18,400	 $18,400 $36,800	 $5,000 $10,000	 $8,000 $16,000	 $3,000 $6,000	 $6,000 $12,000
Preventive care	100% covered	50%*	100% covered	50%*	100% covered	50%*	100% covered	50%*
Virtual care	100% covered	50%*	100% covered	50%*	100% covered	50%*	100% covered	50%*
Office visit	30%*	50%*	$30 copay	50%*	$30 copay	50%*	$20 copay	50%*
Specialist	30%*	50%*	$50 copay	50%*	$40 copay	50%*	$30 copay	50%*
Emergency room	30%*	30%*	$250 copay	$250 copay	$250 copay	$250 copay	$175 copay	$175 copay
Urgent care	30%*	50%*	$50 copay	50%*	$40 copay	50%*	$40 copay	50%*
Inpatient care	30%*	50%*	$250 copay + 50%*	$250 copay + 50%*	$175 copay + 20%*	$175 copay + 50%*	$175 copay + 10%*	$175 copay + 50%*
Outpatient care	30%*	50%*	50%*	50%*	20%*	50%*	10%*	50%*
Chiropractic	30%*	50%*	$50 copay	50%*	$40 copay	50%*	$30 copay	50%*
X-Rays (Physician/ Hospital)	30%*	50%*	$30 copay / 50%*	50%*	100% covered / 20%*	50%*	100% covered / 10%*	50%*
Complex Imaging	30%*	50%*	50%*	50%*	20%*	50%*	10%*	50%*
Prescription Drugs - Team Member Pays:								
Retail (30-day supply)								
Tier 1 — Lowest Cost	30%*	50%*	$10	$10	$10	$10	$10	$10
Tier 2 — Mid-Range Cost	30%*	50%*	$30	$35	$30	$30	$25	$25
Tier 3 — Highest Cost Option	30%*	50%*	$50	$60	$50	$50	$40	$40
Specialty Tier	30%*	Not covered	$75	Not Covered	$75	Not Covered	$75	Not Covered
Mail order (90-day supply)								
Copays	30%*	N/A	2.5x retail	N/A	2.5x retail	N/A	2.5x retail	N/A

***After deductible**

Team Members can elect the medical and prescription drug plan without enrolling in the dental or vision plan.

Weekly Contributions	HDHP with HSA	Basic Plan	Plus Plan	Premier Plan
Team Member	$34.54	$34.25	$64.63	$92.23
Team Member + Spouse	$135.87	$137.13	$196.59	$247.14
Team Member + Child(ren)	$66.04	$65.62	$120.77	$170.70
Family	$148.98	$149.43	$235.41	$310.92

Important:

Shake Shack offers coverage to domestic partners and dependents on all coverages. For specific rates please refer to your enrollment page in workday.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH HSA

What is a Health Savings Account (HSA)?

Those enrolling in the HDHP are able to open a Health Savings Account (HSA) that you can contribute pre-tax dollars to in order to pay for qualified medical expenses, save money year over year, and invest once you reach a certain balance. Unlike an FSA, HSA dollars do not expire and are yours to keep, regardless if you change health plans or jobs in the future.

The HSA:

- Contains funds you can use to help pay eligible medical expenses, including your deductible.
- Is owned by you, so you can use it to save for future medical expenses, even into retirement.

Benefits of HSA

Offers you triple tax savings:

- Contributions are made on a pre-tax basis, lowering your taxable income.
- Tax-free withdrawals to pay for qualified medical expenses (including Dental and Vision).
- Interest and investment earnings are tax-free.

Use Your HSA Funds to Pay for Services

- The contributions to the HSA will help offset the upfront costs incurred under an HDHP, as you must cover 100% of the costs up to the deductible.

Save and Invest:

- If you do not spend the HSA contributions on medical expenses, that money rolls over year over year and is always yours to keep or spend.
- If you reach a minimum balance of $1,000, you may invest your HSA dollars to grow the balance, all through the WEX app.

You Own Your HSA

It goes where you go and carries over each year. You also have the ability to invest once your balance is $1,000 or greater – investments are available to be chosen within the WEX app and are determined by you.

Every little bit counts, and adds up quickly...

If you save:	Balance in 5 yrs	Balance in 10 yrs	Balance in 15 yrs
$50 per month	$3,000	$6,000	$9,000
$100 per month	$6,000	$12,000	$18,000
$250 per month	$15,000	$30,000	$45,000

Please note the above graphic does not account for those who invest HSA funds. If you invest your HSA funds, these balances could be even greater!

Important:

You **must** be enrolled in the High Deductible Health Plan (HDHP) in order to enroll in and contribute to the HSA.

2026 Annual HSA Contribution Limits:

Coverage Level	Contribution Limit (including Shake Shack contribution)	Shake Shack Contribution	Age 55 or older (the maximum contribution increases by $1,000)
Team Member Only	$4,400	$150	$5,400
Family	$8,750	$300	$9,750

Note: To comply with federal requirements under the Patriot Act, identity verification is required before accessing HSA funds.

United Healthcare

MEDICAL PLAN RESOURCES

UnitedHealthcare | myuhc.com | 866.414.1959

What Is Covered as Preventive Care?

- Vaccinations
- Annual physicals
- Pregnancy care
- Colonoscopies (if of recommended age)
- Mammograms (if of recommended age)

Use Virtual Visits When...

- You have a nonemergency condition
- Your doctor is not available
- You become ill while traveling

Not When...

- You have a broken bone or sprain
- Your condition requires an exam or test
- It is a complex or chronic condition

UNITEDHEALTHCARE (UHC) ONLINE TOOLS

Pre-Enrollment: whyuhc.com/shakeshackenterprises

Compare plan offerings, see tools and resources, find medication information.

Post Enrollment: myuhc.com

- 24/7 online access
- Find in-network doctors and facilities, view or print your ID card, check claims, and more all in the myuhc.com website or on the mobile app
- Set up your account

1. Go to myuhc.com
2. Click on Register Now. You will need your ID card or your Social Security number and DOB
3. Follow the step-by-step instructions to create your account

How to Find a Provider

1. Log in to myuhc.com using your username and password
2. Select "Find Care"
3. Select "Medical Directory"
4. Select "People"

Are Your Prescriptions Covered?

You can view your Prescription Drug List (PDL) which shows what prescriptions are covered under your plan. You can view your plan's PDL on myuhc.com. All you need is your member ID number from your ID card.

UnitedHealthcare App

The UnitedHealthcare App lets you access your health plan information on the go. Download for free to use the myuhc.com features from your mobile device.

UHC HEALTH AND WELLNESS

United Healthcare

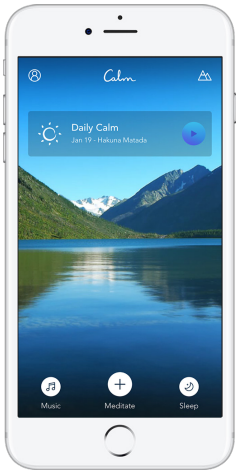
Behavioral Health Support – *Calm Health*

In addition to virtual visits, you and your covered family members also have access to on-demand support through the Calm Health app at no additional cost! The Calm Health app provides tools that help you care for your body and mind including:

Meditation
Teaches the skill of meditation

Work
Sessions to help with burnout and lack of focus at work

Move
Video lessons on mindful movement and gentle stretching



Music
Exclusive music to help focus, relax, and sleep

Sleep
Supports more restful sleep and waking up feeling refreshed

Soundscapes
Soundscapes to help relax, sleep, work or study

Fertility and Family Planning – *Maven*

UHC has partnered with Maven to support all of your fertility and family planning needs. Your Maven Care Advocate meets you wherever you are on your family planning journey –pregnancy or postpartum – and offers you access to on-demand providers, peer support groups, and engaging content. Both you and your partner are eligible to participate in the Maven program at no cost to you.

Participating members gain access to Maven's digital platform which includes:

- Dedicated Care Advocate to help navigate through pregnancy
- Access to diverse resources, including 24/7 virtual specialist providers
- Support 3 months postpartum including return-to-work planning
- Miscarriage and loss support

Health and Fitness – *OnePass Select*

Team Members enrolled in one of the UHC medical plans have access to OnePass Select, a health and fitness discount program. You can choose the membership tier that fits your lifestyle and access a multitude of onsite gyms, digital fitness videos, grocery delivery services, and more. Membership price will vary based on your tier choice – view membership options and enroll at onepassselect.com.

Find your fit with OnePass Select:

At the gym

Choose from OnePass Select's large nationwide network of gym brands and local fitness studios. Use any gym in the network and create a routine just for you.

At home

Work out at home with live or on-demand online fitness classes. Try the workout builder to get routines created just for you, no matter what your fitness level and interests are.

In the kitchen

Get groceries and household essentials delivered to your home. OnePass Select makes it easy to plan for everything you need to enjoy delicious, nutritious meals.

Color At Home Cancer Screenings

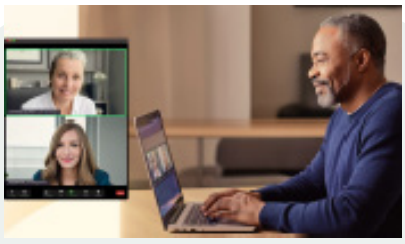
Shake Shack also offers Color, an at-home cancer screening solution that makes evaluating your risk for cancer more accessible. All medically enrolled Shake Shack Team Members can use Color at no additional cost to them.

In our ongoing commitment to employee health, Shake Shack is excited to offer our team members access to Color's confidential health service to help you personalize your health with genetic insights. With just a simple saliva sample, learn what genes say about your risk for common cancers and heart disease, as well as how your body might process certain medications.

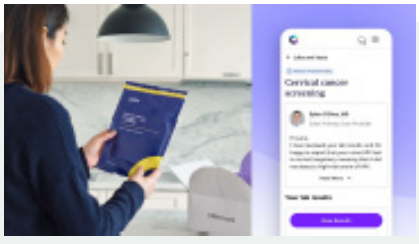
You will receive clinical reports designed to help you and your doctor make better health decisions. You will also get access to genetic counselors and clinical pharmacists to help answer all your questions.

Early Detection	Manage Treatment	Support Survivors
Color helps employees take control of their health with tailored screening strategies. • Personalized risk assessments based on family history, lifestyle, medical data • Individualized screening plans aligned with national guidelines and personal risk factors • Access to imaging services in all 50 states • Education and reminders to improve screening adherence and empower informed decisions	Color ensured employees receive timely, high-quality care with minimal disruption to their lives. • Referrals to top-tier oncologists and treatment centers based on location and condition • Fast access to diagnostics through the nationwide imaging network to avoid delays • 24/7 support for symptom management, medication guidance, and care coordination • Financial and logistical planning to reduce stress and prevent treatment interruptions	Color supports long-term wellness and helps employees reintegrate into work and life. • Five-year survivorship care plans tailored to each individual's recovery journey • Leave and return-to-work coordination, including communication tools for managers and HR • Ongoing behavioral health support through Cancer Connect, addressing anxiety, depression, and emotional resilience • Resources for caregivers and family members, ensuring holistic support beyond the patient

Color's team of cancer experts can help you navigate the health system and manage your personalized screening needs.



Color takes time to understand your unique health history and lifestyle, and designs a personalized screening plan just for you.



Color delivers free cancer screenings to your door, and find and schedule in-network providers, helping you avoid surprise costs.

LGBTQ+ COMMUNITY CARE AND SUPPORT

Having a health plan that supports who you are matters. Some of the benefits included in our plans may be of interest to members and allies of the LGBTQ+ community. From HIV services to gender-affirming care and more, we hope you find these benefits useful, helpful and meaningful.

Advocating for your well-being

Understanding and support go a long way. Our United Healthcare Advocates are trained to provide LGBTQ+ members and allies with a welcoming, open environment designed for easier conversations.

We can help you with:

- Benefit questions
- Finding or scheduling appointments
- Claim information and authorization

Who's covered?

These benefits are available for plan members and their eligible dependents, which may include spouses, domestic partners and children. Check your plan coverage on myuhc.com for more details.

LGBTQ+ inclusive care benefits

HIV prevention and services

Your plan provides support to help keep you and your loved ones healthy, including:

- HIV screenings
- PrEP medications, as well as necessary clinic visits and lab tests*
- PEP medicine
- HIV treatment*

Behavioral health support

Our network of behavioral health clinicians offers confidential support to help with challenges you may be dealing with, such as:

- Stress, anxiety and depression
- Bipolar and related disorders
- Trauma and post-traumatic stress disorder (PTSD)
- Grief, loss and more

Virtual behavioral care is also available with a licensed therapist.

Gender-affirming care

Gender-affirming procedures and services may include:

- Breast surgery
- Genital surgery
- Hormone therapy
- Hair removal required for reconstructive surgery
- Hysterectomy (removal of uterus)
- Tracheal shave
- Voice modification therapy
- Voice modification surgery

Family formation

A variety of family planning benefits are offered that may be covered by your employer.

When an employers selects UnitedHealthcare standard benefits, fertility preservation is covered if an individual is undergoing gender-affirming surgery that will render them permanently infertile/sterile. This includes egg retrieval or sperm collection, cryopreservation and storage for 12 months. For additional information regarding family formation benefits, please contact an Advisor.

Specialized transgender member support

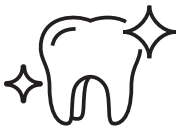
Call 1-800-326-9166. Advisors are available 7:00 a.m.-6:30 p.m. CT, Monday-Friday.

Find an LGBTQ+ supportive provider

Go to Find Care & Costs on myuhc.com and type LGBTQ supportive in the search bar or select in the filter menu.

Important: Pre-certification or prior authorization is required for gender-affirming surgical treatment. Coverage for certain services may vary. Reference your medical plan documents or connect with an Advisor for more information.

You may file a claim appeal within 180 days if you or your physician disagrees with a pre-certification or prior authorization decision, or your claim is denied. Reference your medical plan documents for more information. Advocates are available to help you file an appeal.



DENTAL BENEFITS

Cigna | cigna.com | 800.244.6224

Shake Shack's dental plans are administered through Cigna and provide you and your family with coverage for typical dental expenses, such as cleanings, X-rays, and fillings. You have the option to enroll in a DPPO plan or a DHMO plan.

DPPO Plan

The DPPO plan allows you the freedom to visit any dentist without referrals for all of your dental care. You may seek dental care from any provider; however, your out-of-pocket expenses will be lower if care is provided by a dentist in the Cigna network. Out-of-network providers can also balance bill you for services.

DHMO Plan

The DHMO provides a higher level of benefits and has lower out-of-pocket costs than the DPPO plan. There are no deductibles, benefit maximums, or claim forms. However, you are required to choose a Cigna primary care dentist for all of your dental care and referrals. If you do not use your primary care dentist for all of your services and referrals, the plan does not pay any benefits.

Dental	DPPO	DHMO
Deductible		
Individual	$100	None
Family	$300	None
Is the deductible waived for preventive services?	Yes	Yes
Annual plan maximum (per individual)	$2,000	None
Diagnostic and preventive	Plan pays:	
Oral exams, X-rays, cleanings, fluoride, space maintainers, sealants	100%	100%
Basic		
Oral surgery, fillings, endodontic treatment, periodontic treatment, repairs of dentures and crowns	80%	$0-$225
Major		
Crowns, Inlays/Outlays, Dentures and Bridgework, Repairs	50%	$0-$225
Orthodontia		
Adults and children up to age 19	50% up to $1,500	$1,500/2,000 per 24 month cycle
Lifetime orthodontia plan maximum (per individual)	$1,500	N/A

Weekly Contributions	DPPO	DHMO
Team Member	$4.76	$1.14
Team Member + Spouse	$14.50	$3.13
Team Member + Child(ren)	$14.49	$3.13
Family	$23.87	$10.69

Important:

DHMO plans are not available in the following states/territories: Alaska, Maine, Montana, New Hampshire, New Mexico, North Dakota, South Dakota, Vermont, Wyoming, Puerto Rico, US Virgin Islands and Guam. If a Team Member and/or their dependent live in these states or territories, the DPPO is the only available option.

DENTAL PLAN RESOURCES

Preventive Care

If you are covered under either of the Shake Shack Dental plans, your in-network preventive care is FREE! Semi-Annual cleanings help to prevent the development of more serious issues and lowers your out-of-pocket dental expenses.

Visit cigna.com to find a Cigna dentist in the network. Please refer to Cigna's DPPO Summary Plan Design for more information. You can find a list of services and copays on Cigna's DHMO Fee Schedule or Summary Plan Design.

How to Register Your Account

1. Go to mycigna.com
2. Select Register, or if you already have an account, type in your username and password.
3. You will need a form of identification and will input the requested information.
4. Once all your information is entered, you will be automatically directed into your profile on the MyCigna website.

How to Find a Provider

In the MyCigna portal:

1. Click on the Find Care & Costs tab at the top of the screen.
2. If traveling, change your location, then search by type of provider, name of provider, or reason for visit.
3. Read reviews and find office details on the next screen before choosing the best provider for you!

How to Find Your ID Card

ID cards will be in the top right hand corner of the home page of MyCigna.com after you log in, or use the virtual ID card on the MyCigna app.

How to find discount gym program once you register with Cigna. Click on link: activeandfitdirect.com/fitness/cigna

How to View Your Claims

In the MyCigna portal:

1. Click on the "Claims" tab at the top of the Homepage.
2. On the right hand side of the screen, select the time period and the member for which you would like to review claims for.

MyCigna App

Download the myCigna mobile or visit the MyCigna website to sign in or register to find providers, view your ID card, track claims, review coverage details, and more.

VISION BENEFITS

EyeMed | eyemed.com | 866.939.3633

Shake Shack's Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. Your vision plan is administered through EyeMed. Please refer to the EyeMed Summary of Benefits for more details.

Eye360: Use in-network providers with the designated PLUS logo ( )to have your $10 exam copay waived and get an extra $50 added to your in-network frame or elective contacts allowance.

Vision	In-network		Out-of-network
	PLUS Providers	Non-PLUS Providers	
Eye exam with dilation as necessary (once per calendar year)	$0 copay	$10 copay	Up to $30 allowance
Frames	$210 retail allowance	$160 retail allowance	Up to $112 allowance
Standard Lenses (once per calender year)			
Single vision	100% covered		Up to $25 allowance
Bifocal	100% covered		Up to $35 allowance
Trifocal	100% covered		Up to $70 allowance
Lenticular	100% covered		Up to $70 allowance
Contact Lenses ($20 copay waived)			
Medically necessary	100% covered	100% covered	Up to $300 allowance
Elective		$160 retail allowance	Up to $112 allowance

Weekly Contributions	
Team Member	$1.90
Team Member + Spouse	$3.42
Team Member + Child(ren)	$3.61
Family	$5.70

In-Network Retail Chains

The following are major national chains included in the EyeMed Network.

- America's Best
- Clarkson Eyecare
- Contacts Direct
- Eye Exam CA
- LensCrafters
- MyEyeDr
- Pearle Vision
- Target Optical

If you enroll in vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the Insight network, you will receive a discount on services. To find a network provider, go to eyemed.com or scan the code and select "Insight Network."

VISION PLAN RESOURCES

Preventive Care

If you are covered by Shake Shack's vision plan through EyeMed, your preventive eye exam is only $10, and if you visit a PLUS provider (), your eye exam will be FREE! Eye exams are more than just contacts or glasses, they can help identify more serious health concerns such as diabetes, thyroid disease, and high blood pressure.

How to Register Your Account

1. Visit eyemed.com and click on Member Login
2. If you're a new user, click on Create an Account
3. Register using your member ID or the last 4 digits of your social security number (you'll get an email asking to confirm your account)
4. Finish setting up your account with your email address and a password
5. You're all set! You can change your password, email address, and billing preferences anytime under the Manage Profiles section

EyeMed Mobile App

1. Download: Search "EyeMed Members" in the App Store or Google Play
2. Open: Once downloaded, you can already use some features without logging in, others unlock once you log in/register
3. Register or Log in the same way you would on the website

How to Find a Provider

1. Visit eyemed.com
2. Choose "Find a Provider"
3. Select the Insight network from the network drop down menu
4. Enter in the zip code for the area you want to look for a provider in

Portal Features	Ready when you download	Unlocked when you register
Find nearby network providers	√	
On-the-fly appointment scheduling	√	
Turn by turn directions and map	√	
Eye exam and contact lens reminders		√
Electronic ID card for office visits		√
Save vision prescriptions		√
Benefit plan details		√
Answers to common questions	√	
Special offers and discounts		√
Direct line to EyeMed support	√	

For more information, visit EyeMed's FAQ page here or scan the QR code.

FLEXIBLE SPENDING ACCOUNT (FSA)

WEX | wexinc.com | 866.451.3399

Flexible Spending Accounts (FSAs) enable you to set aside money on a pre-tax basis to pay for your out-of-pocket health care expenses. If you are a Support Center Team Member, Salaried Team Member, or CA Non-Exempt Manager working at least 25 hours per week, you will have a chance to enroll during Open Enrollment or within 90 days of becoming benefit eligible.

Grace Period Benefit

The maximum contribution in 2026 for the healthcare flexible spending account is $3,400* per household. This is a use-it-or-lose-it account, meaning any funds remaining in the account following the close of the plan year will be forfeited. Our plan has a 2 1/2 month grace period and a 90 day submission period to allow you additional time to incur claims and use your FSA funds to pay for these expenses. All services must be incurred from 1/1/26 through 3/15/27. Claims must be submitted by 3/31/2027.

Healthcare FSA

Your Health Care FSA money can pay for expenses in two ways:

- Use your debit card provided by WEX. Keep your receipts to substantiate any claims.
- Complete a claim form indicating that the expense has been incurred during the plan year, along with supporting documents, such as a bill or itemized receipt from the provider. If these items are not available, you may have the care provider acknowledge receipt of payment by signing the claim form.

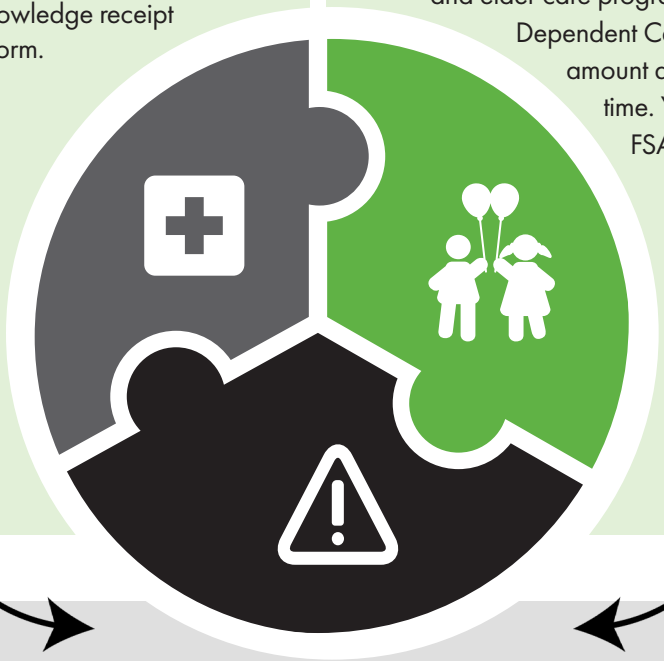
Limited Care FSA

If you select the Shake Shack HSA plan and contribute into a WEX HSA, you are eligible to enroll in a Limited Care FSA alongside your HSA to maximize savings. These funds can be used for qualifying dental, vision, or post-deductible medical expenses.

Dependent Care FSA

The Dependent Care FSA helps pay for expenses associated with caring for child or elder dependents so you or your spouse can work or attend school full time. You may contribute up to $7,500* per year, pretax, or $3,750* if married and filing separate tax returns.

You can use the account to pay for eligible dependent care expenses including day care, after-school programs and elder care programs. Reimbursement from your Dependent Care FSA is limited to the total amount deposited in your account at that time. You cannot use your Health Care FSA to pay for dependent care.



Use It or Lose It

Grace Period until March 15, 2027 – Team Members can spend any unused 2026 funds on claims incurred January 1, 2026 – March 15, 2027 and will have until March 31, 2027 to submit receipts.

***Annual contribution limits are subject to change per IRS ruling.**

COMMUTER BENEFITS

Shake Shack offers monthly tax-free election amounts for eligible workplace commuting expenses. This includes money spent towards mass transit fees and parking payments. Commuter elections can be made or changed at any time by logging into Workday > Benefits > Change Benefits > Additional Benefits.

Spending Account through WEX			
Account	Eligible Team Members	2026 IRS Maximum	Eligible Expenses
Commuter Benefit	Anyone	$340 per month	Work related transportation expenses (mass transit, etc)

Tips

- Regularly check your balance
- Set up a direct deposit account
- Be aware of any deadlines
- Save your receipts and documentation

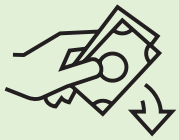
How a Flexible Spending Account (FSA) Works...

Plan

Determine how much to contribute based on the contribution limits.

Spend

Use your funds on eligible expenses by using your debit card or paying up front and submitting for reimbursement.



Collect

Submit IRS-required documentation to substantiate your claims and collect your reimbursement.

- Visit wexinc.com or scan the QR code to login to your secure online site for managing your accounts
- Download WEX's Mobile App, Benefits by WEX for on-the-go account access
- Call 866.451.3399

LIFE INSURANCE

Lincoln Financial | lfg.com | 800.487.1485

Voluntary Life

You have the opportunity to purchase Voluntary Life insurance for yourself, your spouse and/or your dependent children. Your cost for this coverage is based on the amount you elect and your age. You must purchase Voluntary Life insurance for yourself in order to purchase spouse and/or dependent child(ren) coverage. If you did not enroll in this coverage when you were first eligible, you will be subject to medical underwriting.

Coverage	Available benefit	Guaranteed amount
Team Member $10,000 increments	$10,000 to $500,000; or 5x annual salary	$150,000
Spouse $10,000 increments	$10,000 to $250,000 (cannot exceed 50% of Team Member coverage)	$50,000
Dependent child(ren) $1,000 increments	Birth to 6 months — $500 6 months to 26 years — $10,000 maximum	N/A

Age reduction schedule	
Age	Amount of benefit
65	67%
70	45%
75	30%
80	20%

Voluntary Life Team Member and Spouse rates per $1,000 of coverage					
Under 20	$0.060	45–49	$0.179	70-74	$2.257
20-24	$0.060	50-54	$0.285	75-79	$4.559
25-29	$0.065	55-59	$0.458	80-84	$9.057
30-34	$0.080	60-64	$0.701	85-89	$16.697
35-39	$0.090	65-69	$1.270	90-94	$27.244
40-44	$0.119				

Voluntary life child rate per $1,000 of coverage
$0.20

Things to Know about Life Insurance

- A Guarantee Issue (GI) amount is the amount of coverage for which you can be approved without completing a health questionnaire. Guarantee Issue amounts only apply during the 31 days following your initial eligibility period. You will only pay the premium for the GI amount until you are approved for your requested coverage amount.
- If you wish to enroll in the Voluntary Life plan or increase your coverage after your initial eligibility period, you will be required to complete the Evidence of Insurability (EOI) Form.
- Rates are based on your age and the amount of coverage you elect. See the rate table for your weekly contribution.

Enrolling in Voluntary Life		
Status	Timing	Amount
New Hire	Eligible to enroll starting your 45th day for coverage to go into effect on your 90th day of employment	Up to $150,000 without Evidence of Insurability (EOI) for employees, $50,000 for Spouses/ Domestic Partners
Annual Enrollment: Already Enrolled	October 27th through November 17th	You may increase your coverage up to $20,000, and spouses can increase up to $10,000 without EOI
Annual Enrollment: Not enrolled		You may be required to submit EOI for any amount elected

How Much Life Insurance Should I Get?

It's important to give some serious thought to what expenses and income needs your dependents would have if something happened to you. To make sure you have financial protection, here are a few things to consider:

- Daily expenses
- Mortgages and loans
- College tuition

Lincoln's Life Insurance Needs Calculator here may be of assistance in deciding how much Life Insurance you need.

Calculating your per-paycheck cost is easy:

Cost Example: Voluntary Life Insurance Coverage Elected: $25,000, Age 31 on 1/1/2026

If the rate is $0.018 per $1,000 and an enrollee elects $25,000 in coverage, the weekly premium will be $0.45.

$25,000	x	$0.018	=	$450	/ 1,000 x	$0.45
				Weekly premium		per week

Your weekly cost worksheet

$	x		=		/ 1,000 x	$
				Weekly premium		per week

What is Evidence of Insurability (EOI)?

EOI, or Evidence of Insurability, is the information that Lincoln will use to verify your good health when purchasing insurance. It is needed when you are purchasing insurance amounts over the guaranteed issued.

Lincoln's EOI process through the MyLincolnPortal allows you to submit EOI with minimal questions, guided support, and instant acknowledgement of your application, sometimes allowing for automatic approval.

Important

You must designate a beneficiary for your Life Insurance. You have the right to change the beneficiary at any time. You can change your beneficiary by logging into Workday > Benefits > Change Beneficiary.

If you do not have an account with Lincoln yet, go to MyLincolnPortal.com and register using the code "ShakeShack".

20

DISABILITY

Lincoln Financial | lfg.com | 800.487.1485

Shake Shack offers a disability plan through Lincoln Financial to provide financial assistance in case you become disabled or are unable to work.

What Are Common Causes of Disability?

- Pregnancy and childbirth
- Accidental injury
- Cancer

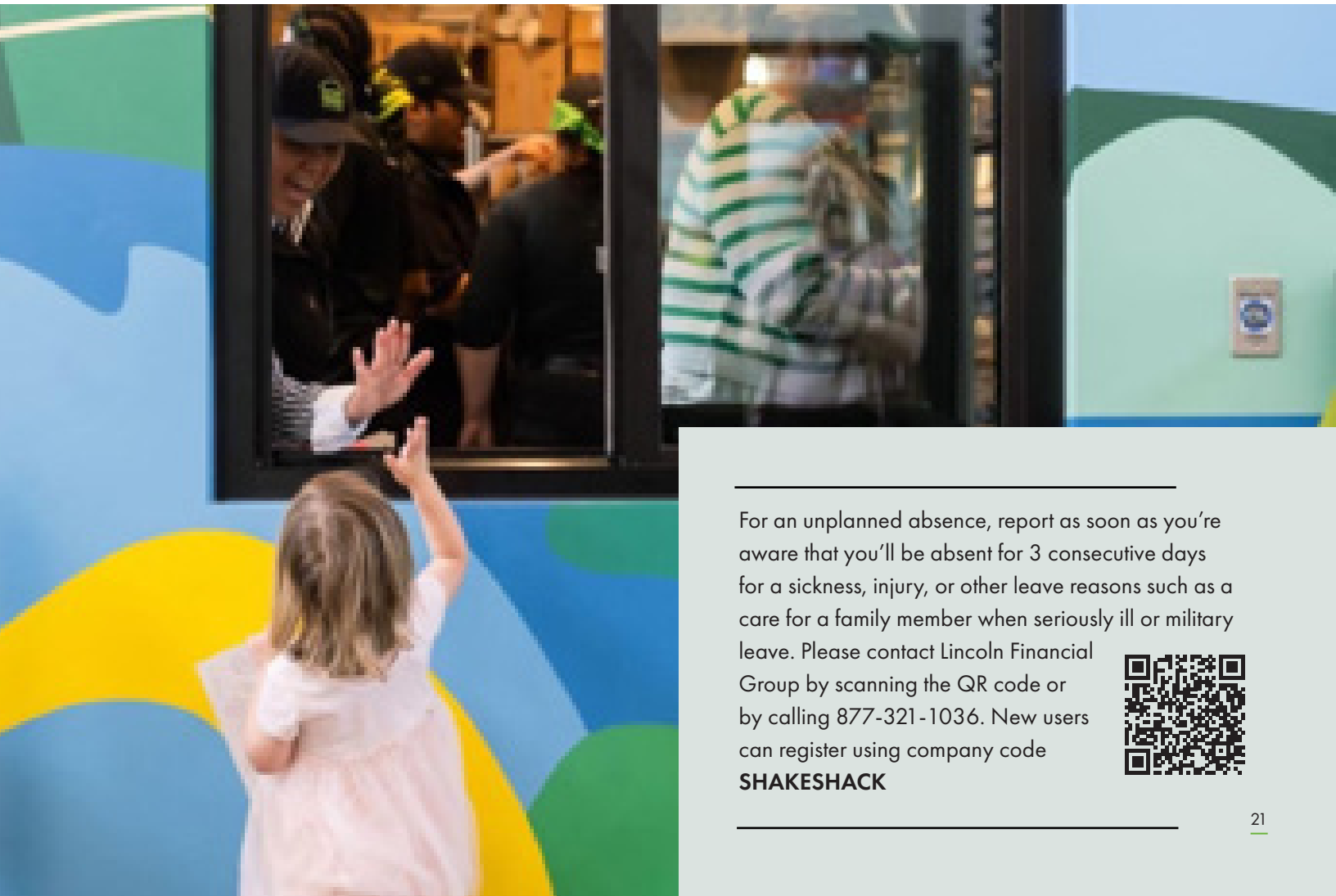
Election is not required. The disability benefits are paid for by Shake Shack; there is no cost to you. However, any income replacement benefits received are taxable.

Short-Term Disability (STD)

Short-Term Disability is available to all Team Members who meet eligibility qualifications (minimum 1 year of service is required). In some states, disability plan supplements the state plan when the state benefit pays less than the Shake Shack plan.

Please note election is not required.

STD Eligibility	100% paid by the employer
Weekly benefit amount	50%
Weekly benefit maximum	$500
Benefits begin	After 7 days of disability
Benefits duration	26 weeks



For an unplanned absence, report as soon as you're aware that you'll be absent for 3 consecutive days for a sickness, injury, or other leave reasons such as a care for a family member when seriously ill or military leave. Please contact Lincoln Financial Group by scanning the QR code or by calling 877-321-1036. New users can register using company code **SHAKESHACK**

401(K) RETIREMENT

Fidelity | netbenefits.com | 800.294.4015

The Shake Shack 401(k) retirement plan is designed to help you prepare for retirement and attain your financial goals. The 401(k) retirement plan makes it easy for you to save money on a tax-deferred basis. When you enroll in the plan, a personal account will be established with Fidelity in your name, funded by:

- Your contributions (pretax and/or Roth).
- Employer matching contributions.
- Investment earnings on both types of contributions.

After completing 12 months of continuous employment, Shake Shack matches 100% up to 3% of your salary, then 50% of the next 2%, with a max match of 4% total when you contribute 6% or more. Contributing at least 6% gets you the full company match!

Your contribution rate	Company match	Company Amount Added	Total investment
1%	100%	1%	2%
2%	100%	2%	4%
3%	100%	3%	6%
4%	50%	3.5%	7.5%
5%	50%	4%	9%
6% and up	Team Member contribution and 4% total company match		

Example: Election of a 3% contribution from $600 weekly pay:

Weekly Pay	Your Contribution at 3%	Company Match at 100% of 3%	Total Contribution
$600	$18.00	$18.00	$36.00

Save pre-tax (Traditional) or after-tax (Roth), lower taxes now or later. Watch your savings grow through investments. Highly Compensated Employees (HCE's) as defined by IRS are not eligible for a match.

Pretax 401(k) contributions

Pretax contributions allow you to reduce your current taxable income. In addition, any earnings on your contributions are tax-deferred. Any contributions and earnings are fully taxable as ordinary income when you withdraw them.

Roth 401(k) contributions

You make Roth 401(k) contributions with after-tax money, so you see no immediate tax benefit. Any earnings from those contributions are tax-free when you take a qualified distribution.

2026 401(k) plan limits:

- Your combined elective deferrals — whether to a traditional 401(k), a Roth 401(k) or both — cannot exceed $23,500* for tax year 2026 if you are under age 50.
- If you are age 50 or older, you may contribute an additional $7,500* in the form of catch-up contributions.
- If you're looking to maximize your contributions in 2026, you may be eligible to take advantage of the "super catch-up" provision for individuals ages 60–63, allowing you to contribute an additional $11,250*. To learn more, please contact Fidelity,

***Annual contribution limits are subject to change per IRS ruling.**

How to Enroll

To enroll in the Plan, go to netbenefits.com and click on "Register Now" if logging in for the first time. If you need assistance, call the Retirement Benefits Line at 800.294.4015. Fidelity has a text feature that you may use to enroll via your mobile device. Please text the word "start" from your mobile device to 343-898.

- **VIEW**
  Review account balances, investments, your personal rate of return, next steps, and more.
- **ACT**
  Change contributions or investments, update your profile or beneficiaries, send paperwork, and more.
- **PLAN**
  See how much you may need in retirement and get your Fidelity Retirement Score

Eligibility

Shake Shack Team Members are eligible to enroll and participate in the 401(k) retirement plan if you are at least 21 years of age with contributions beginning after the completion of 90 days of service.

Beneficiary Designation

An important aspect of estate planning is making beneficiary designations and keeping them up to date after life changes. It's generally quick and easy to assign or update your beneficiary designation by visiting fidelity.com. You will need to provide the name and Social Security number of each beneficiary. If you cannot complete the designation online, you can obtain a paper form.

Important

For additional information regarding Shake Shack's Retirement Plan Highlights please click here

If you have any questions or concerns, please contact Fidelity at 800.343.3548. Retirement specialists are available Monday through Friday, 8 a.m. to 10 p.m. ET.

Download the app by visiting Fidelity.com/go/NetBenefitsapp or by scanning the QR code

Lincoln Financial Group®

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Lincoln Financial | GuidanceResources.com | 833.475.0980

All Team Members and your family members have access to Lincoln Financial's EmployeeConnect services including grief counseling, legal support, financial services, mental health and more.

IN-PERSON GUIDANCE

Some matters are best resolved by meeting with a professional in person. With EmployeeConnect, you and your family get:

- In-person help for short-term needs **(up to five sessions with a counselor per person, per issue, per year)**

UNLIMITED 24/7 ASSISTANCE

You and your family can access the following services anytime — online, on the mobile app, or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more

ONLINE RESOURCES

EmployeeConnect offers a wide range of information and resources you can access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the GuidanceNowSM mobile app. You'll find:

- Articles and tutorials
- Videos

EmployeeConnect counselors are experienced and credentialed

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice, and referrals. All counselors hold master's degrees, with broad-based clinical skills and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor. You'll receive customized support for each work-life service you use.

Lincoln Financial Resources

Visit GuidanceResources.com, download the GuidanceNow mobile app, or call **833-475-0980**. (Username: LFGNY, Password: LFGNY1).

ADDITIONAL BENEFITS & PERKS

Paid Time Off

Shake Shack offers Paid Time Off or Sick Time to all Team Members. This time accrues at a rate determined by your position and years of service with Shake Shack. You are eligible to begin using accrued Paid Time Off or Sick time on the 90th day of employment.

Please refer to the Team Member Handbook if you have any further questions.

Corporate Discounts

PerkSpot, our Team Member discount program, provides exclusive discounts for your favorite local and national merchants.

Please log on to shakeshack.perkspot.com to create your account and access thousands of discounts from apparel to automotive, education to entertainment, toys to travel, and more.

Team Member Dining Discount

As part of our team, you are entitled to a 60% off Team Member Dining Discount at most of our locations around the country (excluding airports & stadiums)! You can use the discount by logging into ShackSource and accessing your unique QR code under "Links."

BASIC INSURANCE TERMS

401(K): A 401(k) plan is a tax-advantaged, defined-contribution retirement account offered by many employers to their Team Members. It is named after a section of the U.S. Internal Revenue Code. Workers can make contributions to their 401(k) accounts through automatic payroll withholding, and their employers can match some or all of those contributions. The investment earnings in a traditional 401(k) plan are not taxed until the Team Member withdraws that money, typically after retirement.

Coinsurance: Coinsurance is your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. Your coinsurance will begin after you have met your deductible. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.

Copay: A copay is a fixed dollar amount you pay for a healthcare service. The amount can vary by the type of service. Your copays will not count toward your deductible but will count toward your out-of-pocket maximum.

Deductible: The deductible is the amount you owe for covered healthcare services before your plan begins to pay benefits. For example, if your deductible is $2,800, your plan won't pay anything until you've met your $2,800 deductible for covered healthcare services subject to the deductible. Preventive care is not subject to the deductible as it is covered 100% by any medical plan option.

Embedded Deductible: If you are on a family medical plan with an embedded deductible, your plan contains two components: an individual deductible and a family deductible. Having two components to the deductible allows each member of your family to have your insurance policy cover their medical bills prior to the entire dollar amount of the family deductible being met. The individual deductible is embedded in the family deductible.

Explanation of Benefits (EOB): An EOB is a statement from the insurance company showing how claims were processed. The EOB tells you what portion of the claim was paid to the healthcare provider and what portion of the payment, if any, you are responsible for.

Individual Mandate: Federal health reform mandates most U.S. citizens have health insurance for themselves and their dependents. Shake Shack helps you stay insured by offering affordable healthcare for all Team Members who work at least 25 hours each week. Coverage is effective after 90 days of full-time employment and allows you to cover your spouse and children.

In-Network vs. Out-of-Network: A network is composed of all contracted providers. Networks request providers to participate in their network, and in return, providers agree to offer discounted services to their patients. If you pick an out-of-network provider, your claims will be higher because you will not receive the discounts the in-network providers offer.

Out-of-Pocket Maximum: The out-of-pocket maximum is designed to protect you in the event of a catastrophic illness or injury. Your out-of-pocket maximum includes your deductible, coinsurance and copays that come out of your pocket. After you have paid the specified out-of-pocket amount during a policy year, the plan pays the remaining covered services at 100%.

Pretax: A pretax contribution is any contribution made to a designated pension plan, retirement account or other tax-deferred investment vehicle for which the contribution is made before federal and municipal taxes are deducted. For example, if you put $10,000 into a 401(k), you do not have to pay tax on that $10,000 of income in the year that it was earned. Pretax contributions are the government's way of encouraging you to save for your retirement.

Preventive Care: Routine healthcare services can minimize the risk of certain illnesses or chronic conditions. Examples of preventive care services include but are not limited to physical exams, mammograms, flu vaccines, prostate tests and smoking cessation.

Reasonable and Customary: The amount of money a health plan determines is the normal or acceptable range of charges for a specific health-related service or medical procedure. If your healthcare provider submits higher charges than what the health plan considers normal or acceptable, you may have to pay the difference.

Vesting: Vesting is a legal term that means to give or earn a right to a present or future payment, asset or benefit. It is most commonly used in reference to retirement plan benefits when a Team Member accrues nonforfeitable rights over employer-provided stock incentives or employer contributions made to the Team Member's qualified retirement plan account or pension plan.

Shake Shack Enterprises LLC

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Shake Shack Enterprises LLC About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM SHAKE SHACK ENTERPRISES LLC ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Shake Shack Enterprises LLC and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Shake Shack Enterprises LLC has determined that the prescription drug coverage offered by the Shake Shack Enterprises LLC Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Shake Shack Enterprises LLC Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Shake Shack Enterprises LLC Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Shake Shack Enterprises LLC Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

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

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 646-844-6496. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Shake Shack Enterprises LLC changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov.

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

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

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

Date:	October 15, 2025
Name of Entity/Sender:	Shake Shack Enterprises, LLC
Contact—Position/Office:	People Resources, Benefit Team
Address:	225 Varick St, Suite 301 NY, NY 10014
Phone Number:	646-844-6496

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

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

SHAKE SHACK ENTERPRISES LLC
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of:

Shake Shack Enterprises, LLC*

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, Shake Shack Enterprises LLC is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if

he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline, provided that you are given a written statement of the reasons for the delay and the date by which the group health plan will complete its action on the request. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include

disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).

21. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

22. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

23. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Melissa Nagelbush
Senior Manager, Benefits
benefits@shakeshack.com
646-844-6496

The Plan's Deputy Privacy Official(s) is/are:

Ron Palmese
Authorized Deputy privacy Official
benefits@shakeshack.com
646-844-6496

Effective Date

The effective date of this notice is: October 15, 2025

NOTICE OF SPECIAL ENROLLMENT RIGHTS
SHAKE SHACK ENTERPRISES LLC EMPLOYEE HEALTH CARE PLAN

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

Loss of eligibility includes but is not limited to:

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

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Melissa Nagelbush
Senior Manager, Benefits
benefits@shakeshack.com
646-844-6496

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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.

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Shake Shack Enterprises, LLC
People Resources, Benefit Team
225 Varick St, Suite 301
NY, NY 10014
benefits@shakeshack.com
646-844-6496

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Shake Shack Enterprises LLC Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 646-844-6496.

For children, you may designate a pediatrician as the primary care provider.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Shake Shack Enterprises LLC Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Shake Shack Enterprises LLC Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

High Deductible Health Plan with HSA	In-Network	Out-of-Network
Individual Deductible	$3,400	$6,800
Family Deductible	$6,800	$13,600
Coinsurance	30%	50%

Basic Plan	In-Network	Out-of-Network
Individual Deductible	$5,000	$10,000
Family Deductible	$10,000	$20,000
Coinsurance	50%	50%

Plus Plan	In-Network	Out-of-Network
Individual Deductible	$2,000	$3,000
Family Deductible	$4,000	$6,000
Coinsurance	20%	50%

Premier Plan	In-Network	Out-of-Network
Individual Deductible	$750	$1,500
Family Deductible	$1,500	$3,000
Coinsurance	10%	50%

If you would like more information on WHCRA benefits, please refer to your or contact your Plan Administrator at:

Melissa Nagelbush
Senior Manager, Benefits
benefits@shakeshack.com
646-844-6496

HEALTH INSURANCE AND MARKETPLACE COVERAGE NOTICE

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the People Resources Benefits Team at 646-844-6496 or benefits@shakeshack.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. **Employer name:** Shake Shack Enterprises, LLC
4. **Employer Identification Number (EIN)**: 26-4487502
5. **Employer address:** 225 Varick St., Suite 301
6. **Employer phone number:** 646-844-6496
7. **City**: New York
8. **State**: NY
9. **ZIP code**: 10014
10. **Who can we contact about employee health coverage at this job?** People Resources
11. **Phone number** (if different from above)
12. **Email address**: benefits@shakeshack.com

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to some employees.

Eligible employees are:
– Those working 25 hours/week or more
– Exempt employees
– California Non-Exempt Employees
– Home Office Non-Exempt Employees

With respect to dependents, we do offer coverage.

Eligible dependents are:
– Legal spouse
– Domestic partner
– Children

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

*** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.*

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

NOTICE FOR SHAKE SHACK'S WELLNESS PROGRAM

Shake Shack offers a voluntary wellness program to employees enrolled in the United Healthcare (UHC) medical plan. The program is administered by UHC according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the Shake Shack wellness program overview flyer. Incentives may be available for employees who participate in certain health-related activities, including a preventive exam or cancer screening. This is a voluntary program, and you are not required to participate. However, employees who choose to participate in the wellness program and complete the established requirements will receive an incentive.

- **For all participants** – If you think you may not be able to meet a standard for a reward under this wellness program, you may qualify for an opportunity to earn the same reward by different means. Contact Benefits@ShakeShack.com and they will work with you and, if you wish, with your doctor to identify an alternative.
- **For participants who may have an impairment** – If you are unable to participate in any of the program events, activities or goals, because of a disability you may be entitled to a reasonable accommodation for participation, or an alternative standard for the incentive. For accommodations related to the Shake Shack wellness program please contact Benefits@ShakeShack.com.

Protections from Disclosure of Medical Information

Your privacy is of utmost importance to Shake Shack. Shake Shack is required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Shake Shack may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The personally identifiable health information that UHC receives will only be used to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Although

no one can prevent all cyber-attacks, UHC has an information security program consisting of people, process, and technology – including encryption and monitoring tools designed to protect electronic information. They maintain safeguards intended to protect electronic information. In the event a data breach, as defined by law, occurs involving information you provided in connection with the wellness program, we will notify you as required by law.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Benefits@ShakeShack.com.

This guide highlights the main features of the Shake Shack Team Member Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Shake Shack reserves the right to change or discontinue its employee benefits plans at any time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

SHAKE SHACK