“Our Mission at the South Point is to Know and Understand Each Customer’s Expectations... Our Goal is to Surpass Them.”

Michael Gaughan’s

SOUTH POINT

Group Benefits Plan

2026

To Our Valued Employees:

At South Point Hotel & Casino we believe our employees are the key ingredient to continued success. We take great pleasure in making available to you the Company Group Benefits Plan. Developed through South Point Benefits, you will find your plan to be a comprehensive benefits package which includes medical, dental, vision, life, and 401(k) retirement, as well as supplemental coverages offering disability, additional life, and personal accident insurance.

We take a hands-on approach with these plans through in-house management, in partnership with selected service organizations who share our goals and vision. This allows us to provide a consistent level of administration, and ensures timely claims processing while maintaining cost efficiencies for both the employees and the Company.

It is important that you read the contents of this Group Benefits Plan booklet so you have a clear understanding of the benefits available to you and how to best make use of your benefits. The cost of your plan is in direct proportion to the claims paid. Therefore, it is important that all employees and their families use their benefits wisely so the costs will remain affordable.

Sincerely,

Michael Gaughan

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Eligibility

Who Can be Covered

All employees of Gaughan South LLC, dba South Point Hotel and Casino, Michael J. Gaughan Airport Slot Concession, Inc., Kroyer Racing Engines LLC, Gaughan Straight Holdings, Inc., and South Point Poker LLC, hereafter collectively referred to as "Group", who are eligible based on the work hours noted below under Initial Eligibility or Continuing Eligibility belong to the eligible group and can be covered.

The words "you" and "your" as used herein refer to an employee of the eligible group.

Initial Eligibility

Employees who are hired as Full-Time will be eligible for healthcare coverage on the first day of the month following 60 days of employment. Employees who are hired as Variable Hour Employees (Part Time) will go through a measurement period of six (6) months starting the first of the month following the date of hire. The required hours worked in a six (6) month measurement period for a Variable Hour Employee (Part Time) is 780 in order to be eligible for coverage.

Continuing Eligibility

Once a non-salaried employee is a member of South Point Benefits, the employee must work a minimum of 780 hours in a six (6) month measurement period. If the employee does not meet the required number of hours in the measurement period they will lose their insurance the first day of the subsequent stability period. At that time the employee will have the option of continuing coverage in accordance with the Federal Law (see "Continuation of Benefits"). Employees on a qualified leave (ie; FMLA, USERAA, and unpaid Jury Duty) will receive credit for work hours missed during their leave of absence. Employees on personal leave of absence will not receive credit for hours missed during their leave of absence (see additional information under "Leave of Absences").

Exceptions to the above eligibility requirements are listed below:

If you are a specialty room server, bus person, host, cashier, or a commissioned Spa person, the minimum number of hours is 700 in a (6) month measurement period.

Measurement and Stability (Benefit Periods)

Measurement Periods	Administrative Periods	Stability (Benefit) Periods
April 16 - Oct. 15	Oct. 16 - Dec. 31	Jan. 1 - June 30
Oct. 16 - April 15	April 16 - June 30	July 1 - Dec. 31

If an employee obtains 780 or more hours during the plan's six (6) month measurement period, they will remain enrolled in the South Point Health Plan during the plan's subsequent stability period. If an employee fails to obtain 780 or more hours during the plan's six (6) month measurement period, they will lose their insurance and their hours will be reviewed again during the next ongoing measurement period.

All Employees

Formal enrollment in the plan or waiver of benefits is required by each employee.

The Active Work Requirement

In order for coverage to begin, you must be actively at work. To qualify as being actively at work, you must have performed the regular duties of your occupation for a full work day on the day before your coverage begins and you must be able to work on the day it is to begin, either at your employer's regular place of business or at some location to which you are required to travel to do your work. This provision only applies if you were absent from work for a reason other than a health factor.

If you do not meet the active work requirement on the date your coverage would otherwise begin, it will begin on the next day on which you meet this requirement.

Effective Date

The effective date for eligible employees will be subject to the timely completion of enrollment forms. If an eligible employee fails to enroll with South Point Benefits by completing the required forms and applications within the 31 days after the 1st day of eligible coverage, then coverage may only become effective in accordance with the "Annual Late Enrollment" or "Special Enrollment" provisions.

Enrollment

You will receive a letter from the South Point Benefits office when you become eligible for your medical benefits. You must come to the Benefits Office within 31 days of your eligibility date to enroll in the plan. If you do not properly enroll in the plan when you are first eligible or if you allow your coverage to lapse, the annual late enrollment rules apply. See "Documentation Requirements" for enrolling a spouse or child.

Annual Late Enrollment

If an employee does not properly enroll in the plan when he/she is first eligible or if the employee allows his/her coverage to lapse, the employee may later enroll during the plan's designated Annual Late Enrollment period as a "late enrollee" provided the employee worked the minimum hour requirement in the (six (6) month measurement period of April 16th thru October 15th of the same year, as indicated under "Continuing Eligibility". The annual late enrollment period is December 1st - December 15th. Changes made during this period will be effective January 1st of the following year.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty days after your other coverage ends. To add new dependents due to marriage, birth, adoption or placement for adoption, see "Adding New Dependents".

Coverage for You and Your Dependents

When you are covered under this plan, you may also cover your eligible dependents. Coverage is offered on a contributory basis through payroll deduction. **Your cost of coverage per pay period for you and your dependents is as follows:**

	HPN Solutions	
	HMO	**POS**
Eligible Employee	**FREE**	**$30.00**
Eligible Dependent (Spouse)	**$20.00**	**$30.00**
Each Eligible Dependent (Child)	**$15.00**	**$20.00**

In order for coverage to be in-force on your eligibility date, you must have signed a payroll deduction authorization.

If you and your spouse are both covered as employees of the eligible group, either of you, but not both of you, may cover your eligible children.

Who are Your Dependents

Your eligible dependents are:

A. Your legal spouse, unless you are legally separated or divorced; **however, if your spouse is eligible as an employee for group health coverage (including dental and vision), through another employer and has declined that coverage**

for any reason, then he/she will not be eligible for full dependent coverage under this plan (see "Order of Benefit Determination");

B. Your dependent children who are less than 26 years of age, except for a child who is a covered employee of this plan. When a dependent is no longer eligible as a dependent, the employee must come into the South Point Benefits office to complete a deletion form in order to stop the payroll deduction.

For purposes of medical care benefits, a child who is covered the day before their 26th birthday as your dependent and has an intellectual disability or is physically handicapped and incapable of earning a living may continue to be covered as your eligible dependent. You must furnish satisfactory proof of such incapacity within thirty days after the child's 19th birthday that the child is chiefly dependent on you for support. You may be required to furnish periodic proof of such child's continued incapacity and dependency but not more often than annually after the child's 26th birthday. If such proof is not satisfactory, coverage for that child will end immediately.

Dental and Vision benefits for dependent children will cease upon the attainment of age 19, unless coverage has been extended under the provisions of the above-mentioned paragraph.

When Coverage for Dependents Begins

Initial Coverage
Coverage under the plan for your eligible dependents can begin on the same date as your own, provided you have signed a payroll deduction authorization and comply with the documentation requirement as indicated under "Documentation Requirement".

Adding New Dependents
Newborns, adoption and placement for adoption will be effective

the date you acquire the new dependent provided you enroll the child within 30 days of the event and provide proper documentation. Additions due to marriage or loss of other coverage will be effective the first of the month following the event provided you complete the enrollment form and provide proper documentation within 30 days of the event.

You must report these changes within 30 days of the event, and sign a **new** or **change in status** payroll deduction authorization. If you do not enroll for your newly added dependents within the allowed time, they will not be eligible to enroll until the annual late enrollment period.

Documentation Requirements

For both initial coverage and adding new dependents, proper documentation will be required for dependent coverage to begin:

Dependent	Documentation Required
Spouse	Marriage Certificate
Newborns	Birth Confirmation until Birth Certificate is received
Children	Birth Certificate
Step-Children	Marriage Certificate and Child's Birth Certificate
Adopted Children	Legal Adoption Paper

If you do not have the marriage certificate, birth certificate, or adoption papers, you may provide the prior year's tax return if it includes your spouse and/or children.

These documents must be provided to the South Point Benefits office within 30 days of the dependent eligibility date; otherwise, the dependent will not be eligible to enroll until the annual late enrollment period.

When Your Coverage Ends

Your coverage will end on the earlier of the following dates:

A. Upon termination of active employment;

B. On the date the covered employee ceases to be a member of the eligible group;

C. On the termination date of the plan.

When Your Dependents' Coverage Ends

Your dependents' coverage under the plan will end on the earlier of the following dates:

A. When the coverage of the covered employee is terminated;

B. When you cease making the required contribution toward your dependent coverage;

C. When the covered dependent ceases to meet the definition of a dependent (see "Who Are Your Dependents");

D. When a dependent spouse becomes eligible as a covered employee; or, when a dependent child becomes eligible as an employee under this plan.

E. When dependent coverage is discontinued under the plan; or

F. On the termination date of the plan.

Cancellation of Dependent Coverage

The following is a list of Qualifying Events that allow cancellation of dependent coverage and discontinuation of your pre-tax premiums other than during the Annual Late Enrollment period:

- Becoming eligible for other coverage

- Death of a spouse or child

- Divorce / Legal Separation / Annulment

- Loss of eligibility when a covered dependent ceases to meet the definition of a dependent (see "Who Are You Dependents")

- Termination of a Qualified Medical Child Support Order (QMCSO)

You must provide proper documentation to the South Point Benefits office within 30 days of the date of the event.

Leave of Absences

In compliance with the Family and Medical Leave Act of 1993 (FMLA), your coverage will be continued, for all leave of absences designated as FMLA by the Human Resources Department. You may be eligible for a leave of absence under FMLA for one of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;

- To care for the employee's spouse, son or daughter under 18 years of age, or parent who has a serious health condition; or

- For a serious health condition that makes the employee unable to perform the employee's job.

You may continue your group benefits on an authorized leave in excess of the 12 weeks FMLA leave or personal leave not related to

FMLA subject to self-payments for you and your dependent coverage contributions. Please note that a leave of absence (other than a qualified FMLA leave) could result in failure to meet the 6 month measurement period (see "Continuing Eligibility").

Leave of Absences and Supplemental Insurance Coverage

If you have a supplemental insurance product and fail to make a premium payment due to a leave of absence (or other reason), it is your responsibility to contact the South Point Benefits office at 702-797-8940 to arrange for self-payment. If you fail to make your premium payments in a timely manner your coverage will terminate. You will then have to wait until annual late enrollment to re-apply. You will need to complete an evidence of insurability form and be approved for coverage by the carrier.

Section 125 Account

South Point Benefits employee and dependent coverage premiums are deducted on a pre-tax basis automatically when you sign up for the plan. If you do not want your premiums pre-taxed you need to sign a form in the Benefits office declining participation.

Notice of Privacy Practices

A member of this plan may obtain a copy of the South Point Benefits notice of privacy practices in the benefits office or by visiting the web link at www.southpointteam.com

South Point Medical Benefit Plans

South Point offers you two medical plan choices.

A HMO plan and a Point of Service (POS) plan.

Both plans are fully insured with Health
Plan of Nevada/Sierra Health and Life
a UnitedHealthcare Company.

With the HMO plan you must
select a Primary care Physician (PCP).
Referrals are needed to see a specialist or
other healthcare providers. This plan is
a little less expensive (see page 4).

With the Point of Service Plan (POS)
you have a variety of benefits and covered
services available within a three-tier plan design;
a HMO, PPO, and out of network benefits.

If you enroll you must select one of the plans above.
Eligible dependents, if added, will be covered under
the same plan you choose to be covered under.

Dental Expense Benefits for Employees, Spouses and Dependent Children Under 19 Years of Age

Schedule of Benefits

Type of Service	Preferred Provider	Non-Preferred Provider
Preventative Care Services	Covered at 100% up to the $2,000 calendar year maximum (each individual).	The same annual maximum applies. Additionally, you will be responsible for charges that exceed the plan allowance.
Basic Services	Covered at 75% of plan allowance, up to the $2,000 calendar year maximum (each individual) after a $75 deductible.	The same annual maximum, deductible, and co-insurance apply. Additionally, you will be responsible for charges that exceed the plan allowance.
Major Services	Covered at 50% of plan allowance, up to the $2,000 calendar year maximum (each individual) after a $75 deductible.	The same annual maximum, deductible, and co-insurance apply. Additionally, you will be responsible for charges that exceed the plan allowance.

Dental Expense Benefits for Employees, Spouses and Dependent Children Under 19 Years of Age

Schedule of Benefits (Continued)

Type of Service	Preferred Provider	Non-Preferred Provider
Orthodontia	Hospitality Dental	Not covered.

Orthodontic benefits are available for all members between the ages of 10 to 18 years. Eligibility for Orthodontic care requires that the employee complete one year of service, and be a member of South Point Benefits. Contact South Point Benefits for more information.

Preferred Dental Providers

Preferred Dental Providers	Address	Phone Number
Hospitality Dental Associates	4955 S. Durango Dr. #201	(702) 933-7275
Quail Park Dental Edward Ruggeroli, D.D.S.	601 S. Rancho Dr. Suite A-3	(702) 382-2311
Radiant Smiles	2633 W. Horizon Ridge Pkwy #130	(702) 897-7001
Radiant Smiles	5095 Blue Diamond Rd #105	(702) 331-0010
Rose Family Dentistry	8490 Eastern Ave.	(702) 914-0000
Siena Hills Family Dental	9330 W. Flamingo Suite 112	(702) 562-2333

Preferred Dental Providers

Preferred Dental Providers	Address	Phone Number
Spanish Hills Dental Steve Wilson, D.D.S.	8910 W. Tropicana #5	(702) 257-9444
Madison Ave Dental	4358 W. Cheyenne Ave	(702) 735-9500
Summerlin Dental	410 S Rampart Blvd #360	(702) 228-2218
Whitney Ranch Dental	1001 Whitney Ranch Drive # 110	(702) 223-2787
Green Valley Dental Group	710 Coronado Center Dr #100	(702) 260-0102
Best Smiles Dentistry **ADULT & PEDIATRICS**	4318 S Eastern Ave.	(702) 776-9926
Mint Dental **PEDIATRICS**	375 N. Stephanie Bldg. #6	(702) 990-7336
Dentistry for Children **PEDIATRICS**	2551 N. Green Valley Pkwy #400-A	(702) 458-6684
Dentistry for Children **PEDIATRICS**	700 E. Silverado Ranch #110	(702) 431-6600
Galaxy Smiles **PEDIATRICS**	9575 W. Tropicana Ave. #5	(702) 633-8331
Kids Dental Safari **PEDIATRICS**	2381-B Renaissance Dr.	(702) 786-6684
Pediatric Dental Care Assoc. **PEDIATRICS**	8981 W. Sahara Ave. Suite 110	(702) 254-4220

Preferred Dental Providers

Preferred Dental Providers	Address	Phone Number
Pediatric Dental Care Assoc. **PEDIATRICS**	6365 Simmons St. #100	(702) 853-7322
Mark Glyman, M.D., D.D.S. Eric Swanson, M.D., D.D.S. **ORAL SURGERY**	Henderson Office 825 N Gibson Rd #441	(702) 892-0833
Mark Glyman, M.D., D.D.S. Eric Swanson, M.D., D.D.S. **ORAL SURGERY**	Summerlin Office 1775 Village Center	(702) 507-5555
Matthew Kukuchi, DMD **ORAL SURGERY**	630 S. Rancho Suite B	(702) 870-2555
Matthew Kukuchi, DMD **ORAL SURGERY**	5765 S Fort Apache Rd #110	(702) 876-6337
Canyon Ridge **Oral and Maxillofacial Surgery** Charles Calder, D.D.S., M.D.	6140 South Fort Apache Rd.	(702) 655-8400
Nevada Endodontics Daniel Shalev, D.D.S. **ENDODONTICS**	2510 Wigwam Pkwy. Suite 200	(702) 263-2000

Your Dental Expense Benefits Coverage

List of Covered Dental Procedures

The following is a list of most common dental procedures. If one or more of the listed procedures would be appropriate according to customary dental practice, the maximum covered charge will be the amount allowable for the lesser charge.

Preventative Care Services

A. Oral examination - initial routine oral examination (limited to one per six months)
B. Prophylaxis (cleaning) - prophylaxis for individuals, treatment to include scaling and polishing (limited to one treatment per six months)
C. Routine x-rays - four bitewing films (limited to one series per six months)

*** Please note: Full mouth x-rays are covered under basic services.**

Basic Services

A. Visits and examinations

1. Fluoride and sealants covered through age 15.
2. Office visit during regular office hours for treatment and observation of injuries to teeth and supporting structure (other than for routine operative procedures)
3. Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)

4. Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general dentist
5. Emergency palliative treatment per visit

B. X-ray and pathology (except for injuries, film fees include examination)

1. Single film
2. Additional films (up to 12)
3. Entire denture series consisting of at least 14 films, including bitewings if necessary (not more than once every thirty-six months)
4. Intra-oral, occlusal view, maxillary or mandibular
5. Upper or lower jaw, extra-oral, one film
6. Upper or lower jaw, extra-oral, two films
7. Panoramic survey, maxillary and mandibular, single film (not more than once every thirty-six months)
8. Biopsy and examination of oral tissue
9. Study models
10. Microscopic examination

C. Oral surgery (includes local anesthesia and routine post-operative care)
1. Extractions
2. Uncomplicated (single)
   a. Each additional tooth
   b. Surgical removal of erupted tooth
   c. Post-operative visit (sutures and complications) after multiple extractions and impaction
3. Impacted teeth
   a. Removal of tooth (soft tissue)
   b. Removal of tooth (partially bony)
   c. Removal of tooth (completely bony)
4. Alveolar or gingival reconstructions

a. Alveolectomy (edentulous) per quadrant
b. Alveolectomy (in addition to removal of teeth) per quadrant
c. Alveoplasty with ridge extension, per arch
d. Removal of palatal torus
e. Removal of mandibular tori, per quadrant
f. Excision of hyperplastic tissue, per arch
g. Excision of pericoronal gingiva

5. Odontogenic cysts and neoplasms
   a. Incision and drainage or abscess
   b. Removal of cyst or tumor up to 1/2"
   c. Removal of cyst or tumor over 1/2"
6. Other surgical procedures
   a. Transplantation of tooth or tooth bud
   b. Maxillary sinusotomy for removal of tooth fragment
   c. Frenectomy

D. Anesthesia - general (only when provided in conjunction with a surgical procedure)

E. Periodontics
1. Emergency treatment (periodontal abscess, acute periodontitus, etc.)
2. Subgingival curettage, root planing, per quadrant (not prophylaxis)
3. Periodontal prophylaxis - considered the same as routing prophylaxis (subject to six month limitation)
4. Correction of occlusion related to periodontal problems, per quadrant
5. Gingivectomy including post-surgical visits (per quadrant)
6. Gingivectomy, osseous ormuco-gingival surgery (including post-surgery visits) per quadrant
7. Gingivectomy, treatment per tooth (fewer than six teeth)

F. Endodontics
   1. Pulp capping (when performed prior to the date of final restoration)
   2. Therapeutic pulpotomy (in addition to restoration)
   3. Vital pulpotomy
   4. Remineralization (calcium hydroxide, temporary restoration) as a separate procedure only

G. Root Canal (including necessary x-rays and cultures, but excluding final restorations)
   1. Single rooted canal therapy (traditional method)
   2. Single rooted canal therapy (sargenti method)
   3. Bi-rooted canal therapy (traditional method)
   4. Bi-rooted canal therapy (sargenti method)
   5. Apicoectomy (including filling of root canal)
   6. Apicoectomy (separate procedure)

H. Restorative dentistry, excluding inlays, crowns (other than stainless steel) and bridges. (Multiple restorations in one surface will be considered as a single restoration).
   1. Amalgam restorations - primary teeth
      a. Cavities involving one surface
      b. Cavities involving two surfaces
      c. Cavities involving three or more surfaces
   2. Amalgam restorations - permanent teeth
      a. Cavities involving one surface
      b. Cavities involving two surfaces
      c. Cavities involving three or more surfaces
   3. Synthetic restorations
      a. Silicate cement filling
      b. Plastic filling
      c. Composite filling involving one surface
      d. Composite filling involving two surfaces
      e. Composite filling involving three or more surfaces

4. Pins - pin (retention) where part of a restoration used instead of gold or crown restoration
5. Crowns - stainless steel (when tooth cannot be restored with a filling material)
6. Full and partial denture repairs
    a. Broken dentures, no teeth involved
    b. Broken denture repairs (metal)
    c. Replacing missing or broken teeth, each tooth
7. Adding teeth to partial denture to replace extracted natural teeth
    a. First tooth
    b. First tooth with clasp
    c. Each additional tooth and clasp
8. Space maintainers (includes all adjustments within six months after installation)
    a. Fixed space maintainer (brand type)
    b. Removable acrylic with round wire rest only
    c. Stainless steel clasps and/or wires, in addition to basic allowance, per wire or clasp

Major Services

Restorative. Cast restorations and crowns are covered only when necessary by decay or traumatic injury and cannot be restored with a filling material.

A. Inlays
    1. One surface
    2. Two surfaces
    3. Three or more surfaces
    4. Onlay in addition to inlay allowance
    5. Crowns
    6. Acrylic
    7. Acrylic with gold

8. Acrylic with non-precious metal
9. Porcelain
10. Porcelain with gold
11. Porcelain with non-precious metal
12. Non-precious metal (full cast)
13. Gold (full cast)
14. Gold (3/4 cast)
15. Gold dowel pin

B. Prosthodontics
1. Bridge abutments (see inlays and crowns)
2. Pontics
3. Cast gold (sanitary)
4. Cast non-precious metal
5. Slotted facing (tru-pontic style)
6. Porcelain fused to gold
7. Porcelain fused to non-precious metal
8. Plastic processed to gold
9. Plastic processed to non-precious metal

C. Removable bridge (unilateral)
1. One piece casting, gold or chrome cobalt allow clasp attachment (all types), per unit including pontics
2. Recementation

D. Inlay
1. Crown
2. Bridge
3. Repairs: crowns or bridges

E. Dentures and partials (fees for dentures and partial dentures include adjustments and relines within six months after installation). Specialized techniques and characterizations are not eligible.

1. Complete upper denture
2. Complete lower denture
3. Partial acrylic upper or lower with gold or chrome cobalt alloy clasps, base, up to 4 teeth and 2 clasps
4. Each additional tooth or clasp
5. Simple stress breakers, extra
6. Stayplate, base
7. Each additional tooth or clasp
8. Relines (chairside or laboratory) and tissue conditioning are allowed once, if at least six (6) months after placement, but not more than once each eighteen (18) months
9. Denture duplication (jump case), per denture
10. Special tissue conditioning, per denture
11. Adjustments to denture more than six months after installation.

Covered Dental Expenses

If you or a covered dependent incurs charges for eligible dental expense benefits, such charges are covered to the extent that they:

A. Are usual and customary as determined by the plan;

B. Constitute necessary treatment; and

C. Are incurred while covered for this benefit.

The plan will pay, at the co-insurance rate, such covered expenses which exceed any applicable deductible amount. The maximum amount payable, deductible amount and co-insurance rates are outlined in the schedule of benefits. For purposes of frequency and annual maximums, the plan uses the prep date versus the seat date.

Payment is subject to the following:

A. The dental treatment plan must be necessary to be considered:

    1. Submission of a dental treatment plan is recommended when charges are expected to exceed $400, unless there is a dental emergency.

B. When a service or supply has an appropriate alternative that is in accordance with accepted standards of dental practice, the service or supply having the lesser charge shall be considered as being the covered charge;

C. The maximum amount payable will not exceed the applicable maximum stated in the schedule of benefits;

D. Covered charges for dental expenses will be considered to be incurred for:

    1. Appliances or modification of appliances on the date the master impression is made;

    2. A crown, bridge or inlay or onlay restoration on the date the tooth or teeth are prepared;

    3. Root canal therapy on the date the pulp chamber is opened; and

    4. All other charges on the date service is rendered or a supply furnished.

Dental Expense Exclusions

Coverage is not provided for services or supplies for which a charge is not customarily made in the absence of coverage. No coverage is provided for loss caused by or resulting from:

A. A partial or full removable denture or fixed bridgework, or for the addition of teeth thereto, or for a crown or gold restoration, if involving a replacement or modification of a denture, bridgework, crown, or gold restoration which was installed during the immediately preceding five years;

B. A partial or full removable denture or fixed bridgework if involving replacement of one or more natural teeth extracted prior to the person becoming covered under the plan, unless the denture or fixed bridgework also includes replacement of a natural tooth which is extracted while the person is covered and was not an abutment to a partial denture or fixed bridge installed within the immediately preceding five years;

C. A service which is an appliance, or modification of an appliance, for which an impression was made before such a person became covered, or a crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or root canal therapy, for which the pulp chamber was opened before such person became covered;

D. A service furnished for cosmetic purposes, unless necessitated as a result of injury. Facing of crowns, or pontics, posterior to the second bicuspid, shall always be considered cosmetic; dental care of a congenital or developmental malformation;

E. Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, or treatment of disturbances of the temporomandibular joint;

F. An orthodontic service and/or replacement of lost or stolen appliances, or appliances or restorations necessary to increase vertical dimension or restore occlusion or for the purpose of splinting (with the exception of ORTHODONTIA);

G. Expenses to the extent of benefits or services otherwise provided under the plan or under any other hospital, surgical, medical or dental plan which the employer contributed to or otherwise sponsors;

H. A service not furnished by a dentist, except:

1. That performed by a licensed dental hygienist under a dentist's supervision; and

2. X-rays ordered by a dentist.

I. Implants and all related charges.

Vision Expense Benefits for Employees, Spouses and Dependent Children Under 19 Years of Age

Schedule of Benefits

Type of Service	Preferred Provider	Non-Preferred Provider
Examination - Visual Analysis once every 24 months	$15 co-pay, plan pays $70 for complete examination.	Plan pays $70, employee pays balance.
Lenses and Frames (or Contact Lenses) once every 24 months	Plan pays up to $150, employee pays balance.	Plan pays up to $150, employee pays balance.

This plan does not provide vision benefits for dependents with other vision coverage

Preferred Vision Providers

Preferred Vision Providers for Examination - Visual Analysis	Address	Phone Number
Mark Doubrava, M.D.	9011 W. Sahara, Suite 101	(702) 794-2020
Shepherd Eye Center	2475 Horizon Ridge Pkwy #120	(702) 731-2088
	3575 Pecos-McLeod	(702) 731-2088
	2100 N. Rampart Blvd.	(702) 731-2088
	9100 W. Post Road	(702) 731-2088
	6850 N. Durango Dr. #404	(702) 731-2088

Your Vision Expense Benefits Coverage

Covered Vision Expenses

If you or a covered dependent incur expenses for any of the services or supplies shown in the schedule of vision benefits, the benefits described in the following pages will be paid, with limitations as noted.

For charges made by a doctor for such services or supplies, the plan will pay an amount equal to the charges but not more than the amount shown in the schedule of vision expense benefits.

Definitions

"Examination-Visual Analysis" means the following services:

A. Complete case history;
B. Measuring and recording of visual acuity, corrected and uncorrected;
C. Examination of fundi, media, crystalline lens, optic disc and pupil reflex for pathology;
D. Corneal curvature measurement;
E. Retinoscopy;
F. Occular fusion, distance and near;
G. Steropsis determination, distance and near;
H. Color discrimination;
I. Analysis of findings;
J. Determining of prescription (if needed);
K. Measuring and recording of visual acuity, distance and near, with new prescription if required; but a complete examination is not necessarily limited to such services.

"Vision Services and Supplies" with regard to lenses or frames, means the furnishing of such lenses or frames and the following services:

A. Professional advice on frame selection;
B. Facial measurement, and preparation of specifications for optical laboratory;
C. Verifying and fitting of prescription glasses;
D. Re-evaluation and progress report two or four weeks after fitting of new prescription;
E. Subsequent servicing; but such services are not necessarily limited to those enumerated.

Vision Expense Limitations

During any period of twenty-four (24) consecutive months payment of no more than one complete examination will be considered eligible expense.

Benefits will be paid for no more than two (2) lenses during any period of twenty-four (24) consecutive months.

Benefits will be paid for no more than one (1) set of frames during any period of twenty-four (24) consecutive months.

Should the covered person prefer to obtain contact lenses rather than lenses and frames, the plan will pay the covered person up to $150, in lieu of lenses and frames. The recipient person would not be entitled to lenses and frames for another twenty-four (24) consecutive months and then only if required on the basis of an optical examination.

Vision Expense Exclusions

Benefits will not be paid for any charges for services or supplies:

A. Which would be furnished on or for which the patient would be entitled to payment under any other provisions (except any provisions for major medical expense benefits) of the plan, but only to the extent that benefits are so payable;

B. Furnished for surgical or medical care and treatment of eye disease or injury;

C. For sunglasses, plain or prescription, or safety lenses or goggles;

D. For orthoptics, vision training, or anisometropia;

E. Which the patient would not be required to pay if there were no coverage;

F. For services or supplies which are not medically necessary for the care and treatment of injury or sickness;

G. To the extent that they exceed either:

1. The customary charge of the individual or organization for the services furnished; or
2. The general level of charges made by others in the same locality for such services or supplies.

Definitions - Dental & Vision Benefits

As Used in the Group Benefits Plan Booklet:

"Co-insurance" means the percentage of plan allowances or billed charges, whichever is less that members must pay a provider. Co-insurance percentage amounts may differ by procedure and are explained throughout the benefits book.

"Covered Expenses" means the charges which are necessarily incurred by reason of diagnosis or treatment of a covered person's condition and which are subject to a plan allowance.

"Dentist" means a duly licensed dentist acting within the scope of his/her license. It includes a physician furnishing covered dental services which he/she is licensed to perform. He/She may not be a member of your or your dependent's immediate family. A dentist is considered a health care provider.

"Experimental or Investigational Treatment (including drugs)" means treatment for which no benefits are payable, and which is verified to be experimental or investigational by relying on information from the American Medical Association, United States Surgeon General, National Institute of Health, American Dental Association, American Osteopathic Association, and the Food and Drug Administration.

"Immediate Family" means your or your dependent's spouse, children, brothers, sisters or parents.

"Injury" means bodily injury caused by an accident. It must result directly and independently of all other causes of loss covered by the plan.

"Late Enrollee" is an individual who enrolls in the plan other than on the earliest date on which coverage can become effective under the terms of the plan.

"Medicare" means all parts of health insurance provided by Title XVIII of the Federal Social Security Act.

"Necessary" means medically necessary as recommended by a physician.

"Physician" means a licensed practitioner of the healing arts acting within the scope of his/her license. He/she may not be a member of your or your dependent's immediate family.

"Plan" means the South Point Hotel and Casino Dental/Vision and Welfare Benefits Plan.

"Plan Sponsors" are South Point Hotel and Casino.

"Plan Year" is the annual period from January 1 to December 31.

"Spouse" a "spouse" is the party to whom you are currently married, and not legally separated, in a marriage that is recognized under Nevada Revised Statutes 122.010 and 122.020.

Survivor Benefits

This section provides important information regarding **term life insurance, personal accident insurance and dependent life insurance.**

Basic Life Benefit

The amount of your term life insurance is $10,000. If your death occurs while you are covered under the Group Benefits Plan, your term life insurance will be paid to anyone you wish to name as your beneficiary. You may change your beneficiary at any time by completing a change in beneficiary form.

This is a guarantee issue plan and no medical questions will be asked. If you become totally disabled while insured and are less than 60 years of age, your insurance may continue during your disability provided you furnish the life insurance provider proof of your total disability within one year from the date you ceased active full-time work.

You may be eligible for additional company paid life based on your wages. See the South Point Benefits office for more information.

Basic Accident Insurance

The principal amount of this coverage is $10,000 for each employee.

Benefits for accidental loss of limbs or eyesight may be payable at an amount less than the principal sum; however, total payments for all losses due to any one accident shall not exceed the principal amount.

Exclusions (may vary by state)

No benefit is paid for loss directly or indirectly caused by any of the following:

- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning. **Exception:** Infection from a cut or wound caused by an accident.
- Riding in or descending from an aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury suffered while in the military service for any country or government.
- Injury which occurs while committing or attempting to commit a crime.
- Use of any drug, narcotic or hallucinogenic agent -
    - Unless prescribed by a doctor;
    - Which is illegal; or
    - Not taken as directed by a doctor or the manufacturer.
- The insured person's intoxication. Intoxication means an individual's blood alcohol content meets or exceeds the legal presumption of intoxication under the law of the state where the accident occurred.

Dependent Life Benefit

In the event of the death of one of your covered dependents while covered under the Group Benefits Plan, you will be paid a death benefit of $2,500 when proof of the dependent's death is received.

Supplemental Insurance Coverage

The goal of the Group Benefits Plan is to protect your financial security by providing a comprehensive list of benefits to include basic life, health, dental, prescription and vision. Since there is a minimal cost for this basic protection, many employees are in a financial position to enhance their package by taking advantage of a number of supplemental programs that offer additional protection at group rates negotiated on your behalf by South Point Benefits.

The supplemental insurance programs include:

- Supplemental Life Insurance
- Personal Accident Insurance (PAI)
- Disability Income Insurance
    - Short Term Disability (STD)
    - Long Term Disability (LTD)
    - Universal Life Insurance with Long Term Care
    - Accident Insurance Preferred Coverage
    - Critical Care Insurance with Cancer Coverage

Most employees will find this to be a convenient and economical way to provide for their insurance needs in excess of the free coverage provided by the company. Rates for Voluntary Insurance Programs are available in the South Point Benefits office.

Supplemental Life Insurance

Life Insurance provides basic protection for your loved ones if something happens to you. While many U.S. households have life insurance, the average amount of coverage is often inadequate to meet family needs or pay off debt. Taking advantage of life insurance coverage provided by your employer can be an important part of your financial security.

Supplemental Life Insurance - Program Basics

- In addition to the Basic Life Insurance provided by South

Point Benefits, eligible employees may elect more coverage by enrolling in a Supplemental Group Term Life Insurance program.

- Basic and Supplemental Life Insurance is underwritten by Principal Financial Group.
- If you decline Supplemental Life coverage upon initial eligibility, you may only apply during the annual open enrollment period and evidence of insurability satisfactory to Principal Financial must be provided.
- You may cancel Supplemental Life coverage at any time.

Supplemental Life Insurance - Coverage Available

For You:

- Apply for Supplemental Life coverage from $10,000 to $500,000 in $10,000 increments, not to exceed 5 times annual salary.
- You are guaranteed $150,000 of Supplemental Life coverage if you elect it during your initial enrollment period.
- If you elect the coverage during your initial enrollment period and wish to increase the amount during the annual open enrollment period, you may apply for coverage up to the guaranteed issue amount without evidence of insurability.
- If you decline coverage during your initial enrollment period, you may only apply for coverage during the annual open enrollment period and evidence of insurability satisfactory to Principal Financial must be provided.
- Benefit amounts reduce to 65% of original coverage at age 70 and to 50% of original coverage at age 75. Refer to your certificate for provisions regarding termination of insurance.

For Your Spouse:

- If you are covered for Supplemental Life, you may apply for Dependent Spouse Life coverage from $5,000 to $250,000 in $5,000 increments. Your spouse will need to provide evidence of insurability satisfactory to Principal for coverage in excess of $50,000.

- Benefit amounts reduce to 65% of original coverage at age 70 and to 50% of original coverage at age 75.
- Dependent Spouse coverage terminates when your spouse is no longer a dependent as defined by your certificate of coverage. Refer to your certificate for provisions regarding eligibility and termination of dependent's insurance.

For Your Children:

- If you are covered for Supplemental Life, you may apply for Dependent Child Life coverage from $2,000 to $10,000 in $2,000 increments.
- This benefit is limited to $1,000 for children ages birth to 6 months.
- If you apply for Dependent Child Life when you are first eligible, no evidence of insurability on your children is required.
- Dependent Child coverage terminates when each child is no longer a dependent as defined by your certificate of coverage. Refer to your certificate for provisions regarding eligibility and termination of dependent's insurance.

You may qualify to convert or port your supplemental life insurance products if you leave the company. If you are interested in converting or porting of your coverage, it is your responsibility to contact the South Point Benefits office at 797-8940 to request a life insurance conversion or portability form. This form must be completed and returned to the South Point Benefits office within 30 days from the date your employment terminates.

Personal Accident Insurance

Personal Accident Insurance (PAI) provides additional protection for your loved ones in the event you are killed or severely injured in a covered accident. PAI can help you or your family deal with expenses and financial obligations that arise in the wake of a serious accident.

Personal Accident Insurance - Program Basics

- Pays additional benefits to employees for a covered accident resulting in the loss of limbs, sight or life. Other losses may also be covered under your employer's plan.
- Unless otherwise indicated in the certificate, benefits are paid directly to the insured employee or his/her beneficiary.
- Spouse coverage available.
- Children coverage available.
- PAI is underwritten by Principal Financial Group.
- If you decline Personal Accident Insurance coverage upon initial eligibility, you may only apply during the annual open enrollment period. No evidence of insurability will be required.
- You may cancel Personal Accident Insurance coverage at any time.

Personal Accident Insurance - Coverage Available

For you:

- Apply for PAI coverage in the following amounts:
  - $50,000
  - $100,000
  - $150,000
  - $200,000
  - $250,000
- Refer to your certificate for provisions regarding termination of insurance.

For Your Family:

- If you are covered for PAI, you may apply for PAI coverage on your family.
- If both your spouse and children are covered, spouse coverage will be 50% of your PAI amount and children coverage will be 10% of your PAI amount. If only your spouse is covered, spouse coverage will be 60% of your PAI amount. If only your children are covered, children

coverage will be 15% of your PAI amount.

- Dependent coverage terminates when your spouse or child is no longer a dependent as defined by your certificate of coverage. Refer to your certificate for provisions regarding eligibility and termination of dependent's insurance.

Exclusions (may vary by state)

No benefit is paid for loss directly or indirectly caused by any of the following:

- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning. **Exception:** Infection from a cut or wound caused by an accident.
- Riding in or descending from an aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury suffered while in the military service for any country or government.
- Injury which occurs while committing or attempting to commit a crime.
- Use of any drug, narcotic or hallucinogenic agent -
    - Unless prescribed by a doctor;
    - Which is illegal; or
    - Not taken as directed by a doctor or the manufacturer.
- The insured person's intoxication. Intoxication means an individual's blood alcohol content meets or exceeds the legal presumption of intoxication under the law of the state where the accident occurred.

Disability Income Insurance

Disability Income coverage protects a percentage of your income if you have an illness or injury and are unable to work for a prolonged

period of time. Weekly Income Benefits help an employee with financial support when an illness or injury strikes and prevents him or her from working for a period of weeks. Monthly Income Benefits help assure financial support that will fill the gap between expenses and income for an extended period of disability.

Disability Income Insurance - Program Basics

- Short Term Disability (STD) provides weekly income benefits. You can elect coverage to replace a portion of your eligible income during disability.
- Long Term Disability (LTD) provides monthly income benefits. You can elect coverage to replace a portion of your eligible income during disability.
- Group Disability Income Insurance is underwritten by Principal Financial Group.
- If you decline Disability Income Insurance coverage upon initial eligibility, you may only apply during the annual open enrollment period and evidence of insurability satisfactory to Principal Financial must be provided.
- You may cancel Disability Income Insurance at any time.

Disability Income Insurance - Coverage Available

Short Term Disability (Weekly Income Benefits)

- 60% of your Basic Weekly Earnings
- Maximum Weekly Income Benefit = $500
- Minimum Weekly Income Benefit = $25
- Benefit Waiting Period for Disability Caused by Accidental Injury = 15 Days
- Benefit Waiting Period for Disability Caused by Sickness = 15 Days
- Maximum Benefit Period = 17 Weeks
- If you elect coverage more than 31 days after you are first eligible, then you must provide Evidence of Insurability satisfactory to Principal Financial.

- Refer to the additional information for Exclusions, Limitations and Offsets that apply to this coverage. Note that all benefits are subject to change.

Long Term Disability (Monthly Income Benefits)

- 60% of your Basic Monthly Earnings
- Maximum Monthly Income Benefit = $6,000
- Minimum Monthly Income Benefit = $100
- Benefit Waiting Period = 120 Days
- Maximum Benefit Period = 5 Years
- If you elect coverage more than 31 days after you are first eligible, then you must provide Evidence of Insurability satisfactory to Principal Financial.
- Refer to the additional information for Exclusions, Limitations and Offsets that apply to this coverage. Note that all benefits are subject to change.

Supplemental Insurance Premium Payments

Your premium payments for supplemental insurance coverage are taken through payroll deductions. If you miss a premium payment due to a leave of absence or other reason, it is your responsibility to contact the South Point Benefits office to arrange for self-payment. If you fail to self-pay in a timely manner, your coverage will terminate. You will then have to wait until annual late enrollment to re-apply. You will need to complete an evidence of insurability form and be approved for coverage by the carrier.

You can only sign up for the Premier Whole Life Insurance, Accident Insurance Your Choice Plan, and Premier Critical Illness Insurance with Cancer Coverage during open enrollment which is December 1st thru December 15th of each year.

Universal Life Insurance with Long Term Care Coverage

Universal life insurance is designed to provide a base of life insurance coverage for your lifetime. It offers you life insurance protection, tax-deferred cash accumulation (based on current tax laws), and cash value loan privileges - all in one policy. The premium you pay is based on the death benefit you select and the optional riders you choose as well as your age and tobacco status. The insurance coverage, premium amounts, and cash value are guaranteed as long as you meet the required premium payments. Long term care benefits are available at 4% of the face value of your policy on a monthly basis to help defer the costs of a long term care facility.

Accident Insurance Preferred Coverage

Features of Accident Insurance

Our Accident Insurance can help cover the unexpected costs related to accident expenses. This policy pays a specified benefit amount for:

- Initial care such as ambulance, emergency room and initial doctor visit
- Follow up care such as outpatient doctor's treatment and medical appliances
- Injuries, including burns, dislocations and fractures
- Catastrophic accident
- Accidental death

Critical Care Insurance with Cancer Coverage

Features of Critical Care with Cancer

Critical Care coverage is a limited benefit policy that provides protection by paying an immediate, lump-sum benefit following the diagnosis of one of several specified diseases or conditions.

Critical Illness Coverage

This policy will pay a one-time lump sum payment of the maximum Critical Illness benefit amount upon diagnosis of:

- Stroke
- Heart Attack
- Coma
- End Stage Renal (Kidney) Failure
- Major Organ Failure
- Permanent Paralysis
- Blindness
- Cancer

A partial benefit of 25% of the maximum critical care benefit amount will be paid upon diagnosis of Coronary Artery Bypass.

A partial benefit of 25% of the maximum critical care benefit amount will be paid upon diagnosis of carcinoma in situ.

Supplemental insurance products and coverages of the products offered are subject to change. Please meet with a benefits counselor during open enrollment to find out what products and coverages are available.

General Information

Exclusions which apply to all Dental, and Vision Benefits

Benefits are not payable:

A. For expenses due to any sickness entitling the patient to benefits under any workers' compensation act or similar law; or

B. For expenses due to any injury arising out of or in the course of any employment for compensation or profit; or

C. For services or supplies received in a hospital owned or operated by the United States government or any of its agencies or for services or supplies furnished by or for such government or its agencies, except to the extent, if any, that charges are made for such services or supplies which the covered person would be required to pay if this coverage were not in effect; or

D. To the extent that they exceed either:
   1. The customary charges of the individual or organization for the services or supplies furnished; or
   2. The general level of charges made by others in the same locality for such services or supplies; or

E. For intentionally self-inflicted injury or self-induced sickness, whether sane or insane; or

F. For expenses due to war or any act of war (declared or

undeclared) or service in the armed forces of any country; or

G. For expenses arising as a result of participation in the commission of a crime or unlawful act or improper conduct; or

H. For travel whether or not recommended by a physician; or

I. For any expenses incurred after the date the plan terminates or for services not listed as covered medical expenses; or

J. For charges incurred outside the United States if the covered person traveled to such a location for the sole purpose of obtaining any services, drugs or supplies.

Coordination with Other Benefits

The purpose of your benefits is to help pay your bills. It is not intended that you receive benefits greater than your bills. This coordination provision is included to help keep the cost of your benefits at a reasonable level and, at the same time, let anyone covered under more than one plan receive as much in benefits as the full amount of his/her allowable expenses. If any person is covered under this plan and one or more other plans, as defined below, the benefits payable under this plan for expenses incurred in a calendar year will be either its regular benefits or reduced benefits which, when added to the benefits of the other plans, will equal 100% of the allowable expenses.

"Plan" means any plan under which dental benefits or services are provided by:

A. Group, blanket or franchise insurance coverage or any other arrangement for coverage of people in a group, whether on an insured or uninsured basis;

B. A hospital service plan or a medical service plan such as Blue Cross and Blue Shield, a group practice plan, or other prepayment coverage;

C. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;

D. Any coverage under government programs or any coverage provided or required by law (i.e., Medicare);

E. Any coverage for students which is sponsored by, or provided through, a school or other education institution.

"Plan" does not include any individual insurance policy or any individual subscription to a Blue Cross-Blue Shield or other service or prepayment plan for which you make premium payments directly to the organization providing the coverage.

"Allowable Expense" means expense incurred (subject to the definition of plan allowance under "Definitions") while eligible for benefits under this plan, part or all of which would be payable under any other plan coordinating with this plan.

"Calendar Year" means a period of twelve consecutive months starting on January 1st and ending on December 31st.

In coordinating benefits, one of the two or more plans involved is the primary plan and other plans are secondary plans. The primary plan pays without regard to the other plans. The secondary plans coordinate their payments so that the total of the payments from all plans will not be more than the allowable expenses. No plan will pay more than it would have paid without this coordination provision.

Order of Benefit Determination

Any plan which does not have a coordination with other benefits or similar provision will pay its benefits first.

All plans which have a coordination with other benefits or similar provision will pay benefits in the order determined by the following rules:

A. A plan which covers the individual as an employee will be considered before a plan which covers the individual as a dependent; however, if your spouse is eligible as an employee for group health coverage through another employer and has declined that coverage for any reason, then he/she will not be eligible for dependent coverage under this plan. This includes dental and vision as well as medical benefits.

B. For dependent children, the plan which pays first is determined by the parents' birthdays. The plan which covers the parent whose month and day of birth occurs earlier in the calendar year will be considered first.

In "B" above, when the natural parents of a dependent child are divorced or legally separated, the following rules apply:

A. If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of that parent will be considered first;

B. If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the step-parent will be considered second. The benefits of a plan which covers the child as a dependent of the parent without custody will be considered third.

C. If there is a court decree which establishes financial responsibility for the medical, dental or other health care expenses of the child, "A" and "B" above will not apply. The plan which covers the parent with financial responsibility will be considered before the benefits of any other plan which covers the child as a dependent. If the parent with court ordered responsibility is eligible as an employee for group health coverage through another employer and has declined that coverage for any reason, then the child will not be eligible for full dependent coverage under this plan; in such a case the benefits of this plan will be limited to the amount which would have been paid had your spouse enrolled in the plan offered by his/her employer, or 20% if you fail to provide full information regarding that plan.

If the above rules still produce a conflict (such as when two plans cover the individual as an employee), the plan which has covered the individual the longest will be considered first.

With respect to the provisions in this section limiting benefits where an eligible spouse elects not to take health coverage from his/her employer, declining coverage includes failure or refusal to authorize or make any required contributions necessary to obtain coverage.

The plan administrator has the right to release to or obtain from any organization or person any information necessary for the administration of this provision and to pay to any organization any amounts necessary to satisfy the intent of this provision.

If the plan has paid any amounts in excess of those necessary to satisfy the intent of this provision, it has the right to recover such excess from the person to or for whom such payments were made or from an insurance company or other organization.

When you claim medical care benefits under this plan, you must furnish the plan administrator information about other coverage which may be involved in applying this coordination provision.

Subrogation of Benefits

If you receive benefits under this plan as a result of an injury or illness caused by another party, the plan has the right to seek repayment of those benefits from the party that caused the injury or illness. In other words, the plan subrogates or substitutes for you and assumes your right to seek recovery from the negligent party. If you bring a liability claim against that person, benefits payable under this plan must be included in the claim and when the judgment is entered on the claim, the claim is settled prior to judgment, or the claim is settled without the filing of a lawsuit, you grant the plan a lien on any proceeds received by you or your attorney, and you must reimburse the plan for the benefits provided without reduction for any attorney's fees incurred to obtain the judgment or settlement. Your obligation to reimburse the plan applies whether or not you and your dependents have received compensation from the third party tortfeasor for your total loss, i.e., whether or not you and your dependents have been made whole.

How to Claim Benefits

You can get the forms you need for claiming benefits from the South Point Benefits office. You can also get help in completing the forms. When forms are properly completed, return them to the South Point Benefits office.

When filing a claim for medical care benefits you must furnish proof of each charge, so it is very important that you have copies of bills for all charges and that the bills are itemized to show the service for which each charge is made.

You may arrange to have benefits for charges of hospital and doctors paid directly to them by signing a form authorizing the plan to pay your benefits in this way.

Notice and Proof of Claim

All benefits provided in the plan shall be paid to you or the provider of service upon receipt of written proof on properly completed claim forms.

Written proof of any loss on which a claim may be based must be furnished to the plan not later than twelve (12) months after the date of such loss.

No action at law or in equity shall be brought to recover on the plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements herein, nor shall such action be brought at all unless brought within six (6) years from the expiration of the time within which proof of loss is required.

Continuation of Benefits Required under Federal Law

An employee whose coverage ends under this employer group health plan may be entitled to elect continuation coverage. Coverage for dependents may also be continued if they are covered under this plan.

The individual must elect continuation coverage during the election period. The individual's coverage must have ended for one of the following reasons:

A. End of employment with the employer for any reason other than gross misconduct;

B. Reduction of hours;

C. Death of the employee;

D. Divorce or legal separation from the employee;

E. Attainment of the maximum age of eligibility by a dependent child.

The coverage is continued the same as the individual had at the time coverage ended, except that death benefit coverage, personal accident insurance coverage and dependent death benefit coverage are not continued. Certain optional continuation coverage may be offered... an explanation of the options are available through the South Point Benefits office.

Notification requirements and election period:

A. In the event of an employee's reduction of hours, end of employment or death, the plan administrator will receive notification;

B. The employee or dependent must notify the plan administrator, named in the summary plan description, within sixty (60) days when divorce, legal separation, marriage or the attainment of the maximum age would end coverage for a dependent;

C. Upon receiving such notification, the plan administrator will notify the eligible employee or dependent of his or her right to elect continuation.

Election period and premium periods:

A. The individual must elect continuation coverage within sixty (60) days after coverage ends or the date the individual is sent notice of his or her right to elect COBRA continuation coverage (the later of).
    1. Premiums are due and payable within forty-five (45) days after the individual elects continuation coverage.
    2. Subsequent premiums are due on the first day of the month during which coverage is extended, and are delinquent after a thirty (30) day grace period.

B. Continuation will end on the earliest of the following dates:
   1. Eighteen (18) months from the date continuation began... for individuals whose coverage ended because of a reduction in hours or end of employment;
   2. Thirty-six (36) months from the date continuation began... for individuals whose coverage ended because of the death of the employee, divorce, legal separation, marriage or the attainment of the maximum age of eligibility by the dependent.
   3. Twenty-nine (29) months from the date of the qualifying event for qualified beneficiaries who are determined, under Title II or XVI of the Social Security Act, to have been disabled at the time of their separation from employment or reduction in hours.

C. The end of the period for which premium is paid if the individual fails to make a premium payment on the date specified by the employer;

D. The date the individual becomes a covered employee under any other group health plan that does not contain any exclusion or limitation to any pre-existing condition;

E. The date the individual becomes entitled to Medicare;

F. The date the dependent spouse remarries and becomes covered under a group health plan that does not contain any exclusion or limitation to any pre-existing condition;

G. The date coverage under this group health plan ends; or

H. The date the employer ceases to maintain any group health plan.

Summary Plan Description

The following information, together with the information given on the preceding pages of this booklet, is intended to furnish the Summary Plan Description required by Section 502 of the Employee Retirement Income Security Act of 1974 (ERISA).

THE GROUP BENEFITS PLAN
FOR EMPLOYEES OF
SOUTH POINT HOTEL AND CASINO

The Plan Sponsors and Administrators are:
SOUTH POINT HOTEL AND CASINO
9777 Las Vegas Blvd., South
Las Vegas, NV 89183
(702) 797-8940

The Employer Identification Number (EIN) of this Plan Sponsor is 35-2275044.

The plan provides life insurance, personal accident insurance, dependent life insurance, medical, dental, and vision benefits. Only the medical, dental and vision benefits are subject to the continuation provisions as set forth by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The general administration of this plan is provided by the Plan Sponsors. The life insurance, personal accident insurance, dependent life insurance, medical, dental and vision care benefits of this plan are provided by South Point Hotel and Casino.

The plan document and the Summary Plan Description may be amended or terminated at any time and for any reason. Authority to amend and/or terminate by resolution is vested with the Group Benefits Committee, consisting of the Chief Executive Officer, the Director of Finance and the Director of Benefits.

The fiscal records of this plan are maintained on the basis of plan years ending on the last day of December.

It is not anticipated that it will ever be necessary to have a lawsuit about this plan; however, if a lawsuit is to be brought, legal process may be served on the Plan Sponsors at the address shown in this section.

The requirements for being covered under this plan, the provision concerning termination of coverage, a description of the plan benefits (including any limitations and exclusions which may result in reduction or loss of benefits) are shown on the preceding pages of this booklet.

The procedures to be followed in presenting claims for benefits under the plan are described on preceding pages entitled "How to Claim Benefits".

If a claim is wholly or partially denied the Plan Sponsors will furnish, within a reasonable time after proof of claims are received, a written notice stating the specific reason or reasons for the denial, pointing out the plan provisions on which the denial is based, and a description of any additional material or information needed to give the claim further consideration, together with the reason it is needed. The notice will also contain an explanation of the plan's claim review procedures.

If a claim has neither been paid nor denied within the ninety (90) days after proof of loss has been furnished, the person making the claim is entitled to have the claim reviewed just as if it had been denied; however, the ninety (90) day period can be extended, but not beyond

an additional ninety (90) days if the Plan Sponsor notifies the claimant in writing before the expiration of the first ninety (90) day period that special circumstances require time for consideration of the claim.

If a claim has been denied or partially denied, the person making the claim may ask to have the claim reviewed. The claimant or someone authorized to represent the claimant should make written request for review to the Plan Sponsors within sixty (60) days after the notice of denial is received. Arrangements will then be made to have the claim reviewed, fully and fairly, by the Plan Sponsor who took no part in the consideration which resulted in the denial. The claimant or his representative may review documents pertinent to the claim and submit issues and comments in writing.

Statement of ERISA Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all participants shall be entitled to:

A. Examine, without charge, at the Plan Administrator's office and at other locations (worksites and union halls) all plan documents, including insurance contracts, any collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

B. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

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

In addition to creating rights for the plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries.

No one, including your employer, a union, or any other person, may fire you or discriminate against you to prevent you from obtaining any benefit under the plan or exercising your rights under ERISA.

If your claim for benefits under the plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such cases, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not provided for reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. The court will decide who will pay the court

costs and legal fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim frivolous.

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the U.S. Labor-Management Service Administration, Department of Justice.