SIERRA HEALTH SERVICES INC
Form 10-K
March 25, 2003

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(MARK ONE)

[X] ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2002

OR

[ ] TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

FOR THE TRANSITION PERIOD FROM _____ TO _____

Commission file number: 1-8865

Sierra Health Services, Inc.

(Exact name of Registrant as Specified in its Charter)

Nevada	**88-0200415**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification Number)

2724 North Tenaya Way
Las Vegas, Nevada 89128

(Address of Principal Executive Offices)(Zip Code)

(702) 242-7000

(Registrant's Telephone Number, Including Area Code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, par value $.005	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes [X] No [ ]

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. [ ]

Indicate by check mark if the registrant is an accelerated filer (as defined in Exchange Act Rule 12b-2 of the Act). Yes [X] No [ ]

The aggregate market value of the voting stock held by non-affiliates of the registrant on June 28, 2002 was $632,537,000.

The number of shares of the registrant's common stock outstanding on March 7, 2003 was 27,592,000.

DOCUMENTS INCORPORATED BY REFERENCE

DOCUMENT	WHERE INCORPORATED
Portions of the registrant's definitive proxy statement for its 2003 annual meeting to be filed with the SEC not later than 120 days after the end of the fiscal year.	Part III

Sierra Health Services, Inc.
2002 Annual Report on Form 10-K

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PART I

ITEM 1. DESCRIPTION OF BUSINESS

GENERAL

Unless specifically indicated or the context clearly indicates otherwise, "Sierra," "we," "us," and "our" refer to Sierra Health Services, Inc. and its subsidiaries.

Overview

We are a managed healthcare organization that provides and administers the delivery of comprehensive healthcare programs with an emphasis on quality care and cost management. Our strategy has been to develop and offer a portfolio of managed healthcare products to employer groups and individuals. Our broad range of managed healthcare services is provided through the following:

- A federally qualified health maintenance organization or HMO;
- managed indemnity plans;
- a subsidiary that administers a managed care federal contract for the Department of Defense's TRICARE program in Region 1;
- a third-party administrative services program for employer-funded health benefit plans and self-insured workers' compensation plans; and

- ancillary products and services that complement our managed healthcare product lines.

Required financial information by business segment is set forth in Note 17 of the Notes to the Consolidated Financial Statements. Segment financial information for prior years has been restated to reflect our current business segments and excludes discontinued operations. Unless otherwise indicated, information presented in this 2002 Form 10-K is for continuing operations and excludes the discontinued Texas HMO health care operations and workers' compensation insurance operations.

Managed Care Products and Services

Our primary types of health care coverage are HMO plans, HMO Point of Service plans, or POS plans, and managed indemnity plans, which include a preferred provider organization, or PPO option. As of December 31, 2002, we provided HMO products to approximately 272,000 members in Nevada. We also provide managed indemnity products to approximately 27,000 members, Medicare supplement products to approximately 19,000 members, and administrative services to approximately 221,000 members. Medical premiums accounted for approximately 67% of total revenues from continuing operations in 2002.

Health Maintenance Organizations.

We operate a mixed model HMO in Las Vegas, Nevada, in which we use our own multi-specialty medical group as well as a network of independently contracted providers. We also operate a network model HMO in Reno, Nevada. Independently contracted primary care physicians and specialists for our HMO are compensated on a capitation or modified fee-for-service basis. Contracts with our primary hospitals are on a discounted per diem or diagnosis related group, or DRG, basis. Members receive a wide range of coverage after paying a co-payment and are eligible for preventive care coverage.

Our commercial plans offer traditional HMO benefits and POS benefits. At December 31, 2002, we had approximately 187,000 commercial members in Nevada. We maintain approximately 59% of the Nevada, and approximately 70% of the Las Vegas, commercial HMO market share.

We also offer a Medicare risk product that we market directly to Medicare-eligible beneficiaries. The monthly payment we receive for Medicare members is determined by a formula established by Federal law. As of December 31, 2002, we had approximately 48,000 Medicare members in Nevada. As of December 31, 2002, approximately 42,000 of our Medicare members were enrolled in the Social HMO, which is discussed below. As of December 31, 2002, our 3,600 Reno members were not participating in the Social HMO, however as of January 2003, over 99% of that membership is now enrolled in the new Reno Social HMO program.

In addition, as of December 31, 2002, we had approximately 37,000 members enrolled in our Nevada HMO Medicaid risk products. To enroll in these products, an individual must be eligible for Medicaid benefits in the state of Nevada. We receive a monthly fee for each Medicaid member enrolled by the state's managed care division.

Social Health Maintenance Organization.

In 1996, we entered into a Social HMO II contract with the Centers for Medicare and Medicaid Services, or CMS, pursuant to which a large portion of our Nevada Medicare risk members receive certain expanded benefits for which we receive additional revenues. The additional revenues are determined based on health risk assessments that have been, and will continue to be, performed on our eligible Medicare risk members. The additional benefits include, among other things, assisting the eligible Medicare risk members with typical daily living functions such as bathing, dressing and walking. These members, as identified in the health risk assessments, are those who currently have difficulty performing daily living functions because of a health problem or physical disability. CMS may consider adjusting the payment factors for the Social HMO members in the future to include a frailty adjuster that uses measures of functional impairment to predict expenditures. The new payment methodology would be implemented gradually. In 2004, should the program continue, we would be paid 70% based on the current payment approach, and 30% based on the new approach which includes the frailty adjuster. The Social HMO program is due to expire at the end of 2003 and, while Congress has extended the program in the past and there are activities taking place on a federal level to continue the program, there is no guarantee that the Social HMO contract will be renewed beyond 2003. If the payment for these members decreases significantly and related benefit changes are not made timely, there would be a material adverse effect on our business and results of operations.

Preferred Provider Organizations.

Our managed indemnity plans generally offer members a PPO option of receiving their medical care from either contracted or non-contracted providers. Members pay higher deductibles and co-insurance or co-payments when they receive care from non- contracted providers. Out-of-pocket costs are lowered by utilizing contracted independent providers who are part of our PPO network. As of December 31, 2002, approximately 27,000 members were enrolled in our managed indemnity plans.

During 2002, we provided managed indemnity, accidental death and disability and/or Medicare supplement services to individuals in California, Colorado, Iowa, Louisiana, Nevada, and Texas. As of December 31, 2002, our managed indemnity subsidiary was licensed in a total of 43 states and the District of Columbia.

Ancillary Medical Services.

Most of our managed healthcare services in Nevada and surrounding rural areas are provided through our independently contracted network of approximately 2,300 providers and 28 hospitals. These Nevada networks include our contracted affiliated multi-specialty medical group, which provides medical services to approximately 76% of our southern Nevada HMO members and employs approximately 180 primary care and other providers in various medical specialties. Through our affiliates, the following services are offered: three urgent care centers; home healthcare; hospice care; behavioral healthcare; home infusion; oxygen and durable medical equipment; a free-standing, state-licensed and Medicare-approved ambulatory surgery center; radiology; vision; and occupational medicine.

These services are provided to members of our HMO, managed indemnity, fee for service and administrative service plans. Mental health and substance abuse services are also provided to approximately 225,000 participants from non-affiliated employer groups and insurance companies.

We believe that this vertical integration of our health care delivery system in southern Nevada provides a competitive advantage as it helps us to effectively manage health care costs while delivering quality care.

Administrative Services.

Our administrative services products provide, among other things, PPO network access and utilization review services to large employer groups that are usually self-insured. As of December 31, 2002, approximately 221,000 members were enrolled in our health administrative services plans. In addition, we provide administration services for self-insured workers' compensation plans. The revenues and expenses for these services are included in investment and other revenues and in general and administrative expenses, respectively, in the Consolidated Statements of Operations.

Military Contract Services

Sierra Military Health Services, Inc., or SMHS.

Pursuant to a triple-option health benefits contract, known as TRICARE, with the Department of Defense, or DoD, SMHS provides managed healthcare coverage to dependents of active duty military personnel, military retirees and dependents of military retirees through subcontractor partnerships and individual providers in Region 1. This region has approximately 678,000 eligible individuals in Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia and Washington, D.C. SMHS also performs specific administrative services, including healthcare appointment scheduling, enrollment, network management and healthcare management services. SMHS performs these services using primarily DoD information systems. SMHS completed an eight month implementation phase in May 1998 and began providing health care benefits on June 1, 1998 under the TRICARE contract.

SMHS will complete the last year of a five-year contract in May 2003, but it has successfully completed negotiations with the DoD to extend the contract for up to four years at the government's sole option on a year-to-year basis. The DoD is also currently procuring managed care services under the Next Generation TRICARE contract, or the T-Nex contract, in a combined and larger North Region (covering Michigan, Ohio, Kentucky, Indiana, Illinois, Wisconsin, Virginia and North Carolina in addition to the areas that make up Region 1 which we currently serve). SMHS submitted its bid to the DoD for the T-Nex contract for the North Region on January 29, 2003, with Sierra as a proposed guarantor. The award decision for this contract is initially expected to be made in mid-2003. Once awarded, the new contractor is scheduled to be fully operational in Region 1 by the third quarter of 2004, based on the current

timetable set by the DoD, and the new contract would supersede the remainder of the contract extension we have negotiated with the DoD under our current TRICARE Region 1 contract. In March 2003, we contributed $35.0 million of the proceeds of the Sierra Debentures to SMHS in furtherance of its bid for the T-Nex contract. (See Liquidity and Capital Resources in Management's Discussion and Analysis of Financial Condition and Results of Operations.)

In June 1996, the DoD awarded a TRICARE contract to TriWest Health Care Alliance, a consortium consisting of Sierra and 13 other health care companies, to provide health services to Regions 7 and 8, which include a total of 16 states. During the first quarter of 2000, we sold our interest in TriWest Health Care Alliance in exchange for a $3.7 million note, which approximated the carrying value of our investment. The note was completely paid in the first quarter of 2001.

Discontinued Workers' Compensation Operations

Workers' Compensation Subsidiary.

On October 31, 1995, we acquired CII Financial, Inc., or CII, for approximately $76.3 million of common stock in a transaction accounted for as a pooling of interests. Through CII's insurance subsidiaries, we write workers' compensation insurance in California, Colorado, Kansas, Missouri, Nebraska, Nevada, New Mexico, Texas and Utah. CII's insurance subsidiaries are licensed in 36 states and the District of Columbia. California, Colorado and Nevada represent approximately 69%, 9%, and 12%, respectively, of CII's fully insured workers' compensation insurance premiums in 2002. CII generated total revenues of $188.8 million in 2002. The workers' compensation subsidiary applies certain managed care concepts to its operations. These concepts include, but are not limited to, the use of specialized preferred provider networks, utilization reviews by an employed board certified occupational medicine physician as well as nurse case managers, medical bill reviewers and job developers who facilitate early return to work.

On January 15, 2003, we announced that we were exploring strategic alternatives for CII. The alternatives may include a sale, spin-off or management buyout. The disposal of the operations was approved by Sierra's Board of Directors on December 31, 2002. Accordingly, beginning in the fourth quarter of 2002, we reclassified our workers' compensation insurance business as discontinued operations. We will continue to operate the business until a disposal occurs.

In conjunction with the decision to dispose of the workers' compensation operations, CII recorded valuation adjustments of $17.3 million, $11.3 million after tax, to reduce this business to its estimated net realizable value upon disposition. The valuation adjustments included the write down of accounts receivable, fixed assets and certain other assets of $4.0 million and additional loss reserves of $8.3 million for the 2002 accident year and $5.0 million for prior accident years.

Marketing

The marketing and sales of our commercial managed care products typically include a multi-step process involving our sales representatives, a consultant/broker appointed by the client and the client. Once a relationship with a group has been established and a group agreement is negotiated and signed, we focus our marketing efforts on individual employees. During a designated "open enrollment" period each year, usually the month preceding the annual renewal of the agreement with the group, employees choose whether to remain with, join or terminate their membership with a specific health plan offered by the employer. New employees decide whether to join one of the employers' health insurance options at the time they begin their employment. Although contracts with employers are generally terminable on 60 days notice, changes in membership occur primarily during open enrollment periods.

We use media communications to convey our emphasis on access to our broad health care provider network and services at a reasonable price. Other communications to customers include employer and member newsletters, member education brochures, prenatal information packets, employer/broker seminars, certain Internet information and direct mail advertising to clients. Members' satisfaction with our benefits and services is monitored by customer surveys. Results from these surveys and other primary and secondary research guide our sales and advertising efforts

throughout the year.

Medicare risk products are primarily marketed by the HMO's sales employees. Retention of employer groups and membership growth is accomplished through competitive pricing and products, customer service and print advertising directed to employers and through consumer media campaigns.

Our workers' compensation insurance policies are sold through independent insurance agents and brokers, who may also represent other insurance companies. We believe that independent insurance agents and brokers choose to market our insurance policies primarily because of the price we charge, the quality of service that we provide and the commissions we pay. As of December 31, 2002, we had relationships with approximately 630 agents and paid our agents commissions based on a percentage of the gross written premium they produced. We gave notice to terminate approximately 145 agents in the fourth quarter of 2002 in an effort to become more selective in the types of accounts we insure. This will result in reduced premiums written in 2003. We also have various agency incentive programs that enable certain agents to earn additional compensation if certain premium production and/or agency loss ratio goals are met.

SMHS administers marketing initiatives in accordance with the TRICARE Region 1 managed care support contract. SMHS' dedicated marketing division uses a multi-faceted marketing approach to ensure that beneficiaries within Region 1 have the opportunity to learn about the health care benefits under TRICARE and have the opportunity to make health care choices that best fit their specific needs. Marketing initiatives include direct beneficiary briefings, direct mail, newspaper advertising, newsletters and Internet web page briefs.

Membership

Period End Membership:

	At December 31,				
	2002	2001	2000	1999	1998
Continuing Operations:					
HMO:					
Commercial	187,000	175,000	140,000	149,000	146,000
Medicare	48,000	45,000	42,000	42,000	37,000
Medicaid	37,000	27,000	15,000	11,000	5,000
Managed Indemnity	27,000	29,000	31,000	37,000	41,000
Medicare Supplement	19,000	23,000	28,000	28,000	26,000
Administrative Services (a)	221,000	196,000	197,000	222,000	242,000
TRICARE Eligibles	678,000	639,000	621,000	610,000	606,000
Total Membership, Continuing Operations	1,217,000	1,134,000	1,074,000	1,099,000	1,103,000
Discontinued Operations:					
HMO:					

Commercial.....	--	43,000	73,000	114,000	126,000
Medicare.....	--	12,000	8,000	11,000	10,000
Total Membership, Discontinued Operations....	--	55,000	81,000	125,000	136,000

(a) 1998 - 2001 membership has been restated to exclude the workers' compensation administrative services only membership.

During 2002, 2001 and 2000, we received approximately 26.6%, 27.6% and 26.3%, respectively, of our total revenues from our contract with CMS to provide health care services to Medicare beneficiaries. Our contract with CMS is subject to annual renewal at the election of CMS and requires us to comply with federal HMO and Medicare laws and regulations and may be terminated if we fail to comply. The termination of our contract with CMS would have a material adverse effect on our business. In addition, there have been, and we expect that there will continue to be, a number of legislative proposals to limit Medicare reimbursements and to require additional benefits. Future levels of funding of the Medicare program by the federal government cannot be predicted with certainty. (See Government Regulation and Recent Regulation).

Our ability to obtain and maintain favorable group benefit agreements with employer groups affects our profitability. The agreements are generally renewable on an annual basis but are subject to termination on 60 days prior notice. For the fiscal year ended December 31, 2002, our eight largest HMO employer groups were, in the aggregate, responsible for less than 10% of our total revenues. Although none of our employer groups accounted for more than 3% of total revenues during that period, the loss of one or more of the larger employer groups could, if not replaced with similar membership, have a material adverse effect upon our business. We have generally been successful in retaining these employer groups in Nevada. However, there can be no assurance that we will be able to renew our agreements with our employer groups in the future or that we will not experience a decline in enrollment within our employer groups. Additionally, revenues received under certain government contracts are subject to audit and retroactive adjustment.

Provider Arrangements and Cost Management

HMO and Managed Indemnity Products.

A significant distinction between our health care delivery system and that of many other managed care providers is the fact that approximately 76% of our southern Nevada HMO members receive primary health care through our own multi-specialty medical group. We make health care available through independently contracted providers employed by the multi-specialty medical group and other independently contracted networks of physicians, hospitals and other providers.

Under our HMO, the member selects a primary care physician who provides or authorizes any non-emergency medical care given to that member. We compensate our independently contracted primary care physicians by using both capitation and modified fee-for-service payment methods. We have negotiated capitation and reduced fee-for-service agreements with our specialty network as well. We monitor certain health care utilization, including evaluation of elective surgical procedures, quality of care and the financial stability of our capitated providers, to facilitate access to services and to ensure member satisfaction.

We provide or negotiate discounted contracts with hospitals for inpatient and outpatient hospital care, including room and board, diagnostic tests and medical and surgical procedures. We believe that we currently have a favorable contract with our primary southern Nevada contracted hospitals, Sunrise Hospital and Medical Center and Mountain View Hospital, or Sunrise and Mountain View. Subject to certain limitations, the contract provides, among other things, guaranteed contracted per diem rate increases on an annual basis. The per diem rate increased 8.8% in 2002

and 8.8% in 2003 for commercial members and the per diem increased 3% in 2002 and 3% in 2003 for Medicare members. The rate increase for 2003 has been factored into our 2003 premium rate increases. Our contract with Sunrise and Mountain View contains a clause which requires them to provide us with their best rates in the market place. Since a majority of our southern Nevada hospital days are at these facilities, this contract assists us in managing a significant portion of our medical costs. We can be and have been affected by these hospitals' limited capacity and have had to place our members in other facilities, some with a higher cost to us, due to a shortage of beds at these hospitals. In general, our other hospital contracts in Las Vegas are based on a fixed per diem rate structure.

For hospitals other than Sunrise and Mountain View, our contracts typically renew automatically with both parties granted the right to terminate after a notice period ranging from three to twelve months. Our current contract with Sunrise and Mountain View expires December 31, 2006. Reimbursement arrangements with other healthcare providers, including pharmacies, generally renew automatically or are negotiated annually and are based on several different payment methods, including per diems (where the reimbursement rate is based on a per day of service charge for specified types of care), capitation or modified fee-for-service arrangements. To the extent possible, when negotiating non-physician provider arrangements, we solicit competitive bids.

For services to members utilizing a PPO plan, we reimburse participating physicians on a modified fee-for-service basis, which incorporates a limited fee schedule, and we reimburse hospitals on a per diem or discounted fee-for-service basis. For services rendered under a standard indemnity plan, pursuant to which a member may select a non-plan provider, we reimburse non- contracted physicians and hospitals at a pre-established usual and customary rate, less deductibles and co-insurance amounts.

We manage health care costs through our large case management program, utilization review, monitoring of care in the appropriate setting and by member education on how and when to use the services of our plans and how to manage chronic disease conditions. We audit hospital bills and review hospital and high volume providers' claims to ensure appropriate billing and utilization patterns. We also monitor the appropriateness of the referral process from the primary care physician to the specialty network. Further, we utilize our home health care agency and our hospice, which help to minimize hospital admissions and the length of stay.

Military Contract Services.

Under the TRICARE contract, dependents of active duty military personnel, military retirees and dependents of military retirees choose one of three option plans available to them for health care services: (i) TRICARE Prime (an HMO style option with a self-selected primary care manager and no deductibles), (ii) TRICARE Extra (a PPO style option with deductibles and cost shares) or (iii) TRICARE Standard (an indemnity style option with deductibles and cost shares). Approximately 37% of eligible beneficiaries receive their primary care through existing military treatment facilities. SMHS negotiated discounted contracts with approximately 42,500 individual providers, 2,500 institutions and 10,000 pharmacies to provide supplemental network access for TRICARE Prime and Extra beneficiaries. SMHS' contracts with providers are primarily on a discounted basis from the TRICARE established fee schedule with renewal and termination terms similar to our commercial practice. SMHS is at-risk for and manages the health care service cost of all TRICARE Extra and Standard beneficiaries, as well as a small percentage of TRICARE Prime beneficiaries.

SMHS implemented the TRICARE Senior Pharmacy Program, or Senior Rx, on April 1, 2001. The Senior Rx program enables Military Health Services Medicare eligible beneficiaries, age 65 and over, to obtain prescription drugs, and the supplies necessary for the administration of pharmaceuticals, from a network of retail pharmacy, non-network retail pharmacy or through the National Mail Order Pharmacy. SMHS does not assume any health care underwriting risk under this new program.

On October 1, 2001, SMHS implemented the TRICARE for Life program. This new DoD program provides continued TRICARE coverage to military family retirees, over the age of 65, as a supplement to Medicare. SMHS does not

assume any health care underwriting risk under this new program.

Risk Management

We maintain general and professional liability, property and fidelity insurance coverage in amounts that we believe, based upon historical experience, are adequate for our operations. Due to recent unfavorable changes in the commercial insurance market, we have, for certain risks, purchased coverage with higher deductibles and lower limits of coverage. Effective June 15, 2002, our primary medical professional liability policy provides first dollar coverage in the amount of $1.0 million per loss event with an annual aggregate limit of coverage per provider of $3.0 million. We have also purchased excess medical professional liability and managed care coverage which requires us to be responsible for coinsurance in the amount of 25% of each and every covered loss. The primary and excess medical professional liability policies apply retroactively to June 15, 2001. In addition, we require all of our independently contracted provider physician groups, individual practice physicians, specialists, dentists, podiatrists and other health care providers (with the exception of certain hospitals) to maintain professional liability coverage. Certain of the hospitals with which we contract are self-insured. We also maintain stop-loss insurance that reimburses us between 50% and 90% of hospital charges for each individual member of our HMO or managed indemnity plans whose hospital expenses exceed $300,000, during the contract year and up to $2.0 million per member per lifetime. In the ordinary course of business, we are subject to claims that are not insured, principally claims for punitive damages and claims that fall within the applicable self-insured retention.

Effective July 1, 1998, all workers' compensation claims with dates of injury occurring on or after that date were reinsured under a quota share and excess of loss agreement, which we refer to as "low level" reinsurance, with Travelers Indemnity Company of Illinois, or Travelers. Travelers is rated AA and A++ by Fitch Ratings and the A.M. Best Company, respectively. The low level reinsurance provided quota share protection for 30% of the first $10,000 of each loss, and excess of loss protection of 75% of the next $40,000 of each loss, and 100% of the next $450,000 on a per occurrence basis. The maximum net loss retained on any one claim ceded under this treaty was $17,000. This agreement continued until June 30, 2000, when we exercised an option for a twelve month extension relating to the run-off of policies in force as of June 30, 2000, which covered claims arising under such policies during the term of the extension.

In addition to the low level reinsurance, effective January 1, 2000, we entered into a reinsurance contract that provides statutory (unlimited) coverage for workers' compensation claims in excess of $500,000 per occurrence. The contract was in effect for claims occurring on or after January 1, 2000, through December 31, 2002. There was a twelve month run out provision in the contract which we exercised. The reinsurer, National Union Fire Insurance Company, is rated AAA and A++ by Fitch Ratings and the A.M. Best Company, respectively.

When the low level reinsurance agreement expired on June 30, 2000, as a result of a general tightening of the reinsurance market as well as the impact of the increased loss experience in California, a comparable type of reinsurance program was unavailable in the market and those reinsurers which were offering other forms of lower retention programs were charging premiums that we believed were not cost justified. Therefore, effective July 1, 2000, we entered into a reinsurance contract with National Union Fire Insurance Company that provided $250,000 of coverage for workers' compensation claims in excess of $250,000 per occurrence. The reinsurer, National Union Fire Insurance Company, is rated AAA and A++ by Fitch Ratings and the A.M. Best Company, respectively. The contract was in effect for claims occurring on policies with effective dates beginning July 1, 2000 and thereafter and for claims incurred prior to July 1, 2001.

In the wake of the events of September 11, 2001 and the ensuing hardening of the reinsurance market, our new reinsurance agreements, which cover new and renewal policies effective on and after January 1, 2003, will cost more with reduced coverage limits, including exclusions for terrorist acts. We continue to retain the first $500,000 per occurrence but the maximum coverage has been reduced from statutory (i.e., unlimited) limits to $20.0 million per occurrence. We also must meet certain annual aggregate deductibles before we can begin to recover from some of our

reinsurers. This new coverage will result in our retaining more of the losses and loss adjustment expense, or LAE. The reinsurers on the new agreement consist of domestic as well as foreign reinsurers, and all are rated at least A- or better by A.M. Best Company as of December 31, 2002.

Information Systems

We use information systems to support, among other things, pricing our services, monitoring utilization and other cost factors, providing bills on a timely basis, identifying accounts for collection, managing the scheduling and delivery of health care services, processing claims for reimbursement, delivering customer service and handling various accounting and reporting functions.

In 2002, we introduced a wireless communications network within our medical provider subsidiary's medical offices to support the rollout of a hand-held electronic prescribing application. We also upgraded the remainder of our workstations to the Windows NT operating system, upgraded the computer hardware supporting core systems and expanded our data back-up and recovery capabilities. Progress toward the Federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, EDI compliance is ongoing and was partially achieved with the completion of HIPAA-compliant EDI transaction processing for claims and enrollment.

There can be no assurance that we will be able to maintain and enhance our information systems including HIPAA compliance. Our failure to maintain and enhance our information systems could have a material impact on our business and results of operations.

We view our information systems capability as critical to the performance of ongoing administrative functions and integral to quality assurance and the coordination of patient care. We are continually modifying or improving our information systems capabilities in an effort to improve operating efficiencies and service levels.

Quality Assurance and Improvement

We promote continuous improvement in the quality of member care and service through our quality programs. Our quality programs are a combination of quality assurance activities, including the retrospective monitoring and problem solving associated with the quality of care delivered and continuous quality improvement activities including the trending and analysis of ongoing aggregate data for purposes of prospective planning.

Our quality assurance methodology is based on (i) reviews of adverse health outcomes as well as appropriateness and quality of care; (ii) focused reviews of high volume/high risk diagnoses or procedures; (iii) monitoring for trends; (iv) peer review of the clinical process of care; (v) development and implementation of corrective action plans, as appropriate; (vi) monitoring compliance/adherence to corrective action plans; and (vii) assessment of the effectiveness of the corrective action plans.

Our quality improvement methodology is based on (i) collection and analysis of data; (ii) analysis of barriers to achieving goals and/or benchmarks; (iii) development and implementation of interventions to address barriers; (iv) remeasurement of data to assess effectiveness of interventions; (v) development and implementation of new or additional interventions, as appropriate; and (vi) follow-up remeasurement of data to assess effectiveness or sustained impact.

Several independent organizations have been formed for the purpose of responding to external demands for accountability in the health care industry. We have voluntarily elected to be evaluated by two of these external organizations, the National Committee for Quality Assurance, or NCQA, and the American Accreditation Healthcare Commission, or URAC. NCQA is an independent, not-for-profit organization that evaluates managed care

organizations. URAC is a non-profit charitable organization founded in 1990 to establish standards for the managed care industry.

The NCQA accreditation process includes rigorous evaluations conducted by a team of physicians and managed care experts. According to NCQA officials, the standards are purposely set high to encourage health plans to continuously enhance their quality. No comparable evaluation exists for fee-for-service health care. NCQA evaluates plans on approximately 50 quality standards that fall into six categories: quality management and improvement; physician credentials; members' rights and responsibilities; preventive health services; utilization management; and medical records. In 2000, Health Plan of Nevada, or HPN, earned an "Accredited" status from the NCQA for its HMO and Medicare products.

HPN, Sierra Health and Life Insurance Co. Inc., or SHL, Sierra Healthcare Options, Inc. and Behavioral Healthcare Options, Inc. utilization management operations were "Fully Accredited" by URAC, under URAC's "Health Utilization Management, or UM, Standards" program. URAC's health UM accreditation program is the largest and most recognized program of its type in the United States. The health UM standards are meant to ensure organizations follow a process that is clinically sound, promotes quality care and respects members' rights. The health UM standards address eight categories including the following: confidentiality, staff qualifications, program qualifications, information upon which organizations conduct UM, procedures for review determination and procedures for appeals of determinations not to certify (expedited and standard appeals). Once the review team is satisfied that the organization is in compliance with the UM standards, the accreditation application is forwarded to the URAC Accreditation committee. This Committee consists of representatives from the URAC member organizations and industry experts. Final approval for accreditation is made by URAC's executive committee. URAC accreditation is awarded for two years, we received our latest accreditation in August, 2001.

There can be no assurance, however, that we will maintain NCQA or other accreditations in the future and there is no basis to predict what effect, if any, the lack of NCQA or other accreditations could have on HPN's competitive position in Nevada.

Underwriting

HMO.

We develop premium rates for our various health plans primarily through a community rating by class, or CRC, methodology. Under the CRC method, all costs of basic benefit plans for our entire membership population are aggregated, projected forward to future periods and expressed on a "per member per month" basis. Subject to certain legal constraints, actuarial adjustments are made to the base premium rates for demographic variations specific to each employer group. Such variations may include, but are not limited to, the average age and gender of their employees, group size, area, health status, and industry. For most employer groups, the adjusted rates are then converted to tiered premium rates for various coverage types, such as single or family coverage. For some small employer groups, the final premium rates are expressed in a table format using age range bands and gender of each employee and dependent.

In addition to premiums paid by employers, members also pay co-payments at the time most services are provided. We believe that co-payments encourage appropriate utilization of health care services while allowing us to offer competitive premium rates. We also believe that the capitation method of provider compensation encourages physicians to provide only medically necessary and appropriate care.

Managed Indemnity.

Premium charges for our managed indemnity products are set in a manner similar to the CRC method described above. The actual health claim experience is used in whole or blended with calculated CRC rates to develop final

premium rates for larger employer groups. This rating process includes the use of utilization experience, adjustments for incurred but not reported claims, inflationary factors, credibility and specific reinsurance pooling levels for large individual claims. Final premium rates are again generally expressed as tiered rates for larger employer groups or as age/gender banded rates for smaller employer groups.

Discontinued Workers' Compensation Operations

. Prior to insuring a particular risk, we review, among other factors, the employer's prior loss experience and other pertinent underwriting information. Additionally, we determine whether the employer's employment classifications are among the classifications that we have elected to insure and if the amounts of the premiums for the classifications are within our guidelines. We review these classifications periodically to evaluate whether they are profitable. We are willing to insure approximately one-half of the approximately 500 employment classifications in California. The remaining classifications are either excluded by our reinsurance treaty or are believed by us to be too hazardous or not profitable. In addition, we increase our requirements for certain classifications to increase the likelihood of profitability.

Once an employer has been insured by us, our loss control department may assist the insured in developing and maintaining safety programs and procedures to minimize on-the-job injuries and industrial health hazards. The safety programs and procedures vary from insured to insured. Depending upon the size, classifications and loss experience of the employer, our loss control department will periodically inspect the employer's place of business and may recommend changes that could prevent industrial accidents. In addition, severe or recurring injuries may also warrant on-site inspections. In certain instances, members of our loss control department may conduct special educational training sessions for insured employees to assist in the prevention of on-the-job injuries. For example, employers engaged in contracting may be offered a training session on general first aid and prevention of injuries from specific work exposures.

Competition

HMO and Managed Indemnity.

Managed care companies and HMOs operate in a highly competitive environment. Our major competition is from self-funded employer plans, PPO networks, other HMOs, and traditional indemnity carriers, such as Aetna and Blue Cross/Blue Shield. Many of our competitors have substantially larger total enrollments, greater financial resources and offer a broader range of products. Additional competitors with greater financial resources may enter our markets in the future. We believe that the most important competitive factors are the delivery of reasonably priced, quality medical benefits to members and the adequacy and availability of health care delivery services and facilities. We depend on a large PPO network and flexible benefit plans to attract new members. Competitive pressures may result in reduced membership levels. Any reductions could materially affect our business and results of operations.

Discontinued Workers' Compensation Operations.

Our workers' compensation business is concentrated in California, a state where the workers' compensation insurance industry is extremely competitive. When open rating became effective for policyholders in 1995, there were substantial reductions in premiums. Starting in the latter part of 1999 however, we and other carriers began increasing rates. In 2002, 2001 and 2000, we received increases on policies renewed in California of 37%, 38% and 26%, respectively. Based on public information, through the third quarter of 2002, other California workers' compensation companies issued year 2002 policies at rates averaging 32% in excess of the expiring rates. Due to the impact of new legislation in California and the continuing higher amounts of average incurred claims we have been experiencing, our rate increase in the first two months of 2003 on renewing California policies is approximately 30 - 50%. In addition, we continue to implement stricter underwriting guidelines. This has resulted in a continuation of lost business, lower amounts of new business and our premiums written for the first two months of 2003 in California are down

approximately 22% over the comparable 2002 period. Premiums written in our other states are also down by approximately 11%, primarily in Colorado. Premium production results for the first two months of 2003 may not be indicative of the full year's premium production.

Premiums in force are an indicator of future written premium trends and represent the total estimated annual premiums of all policies in force at a point in time. Total inforce premiums decreased by 1% from $168.4 million at December 31, 2001 to $166.9 million at December 31, 2002. As noted above, our premiums written in the first two months of 2003 are significantly reduced from the first two months of 2002. Total inforce premiums at February 28, 2003 are $145.0 million, which represents a reduction of 13.1% from December 31, 2002. At February 28, 2003, premiums in force for California business was reduced by 17.2% to $94.8 million and non-California business was reduced by 4.1% to $50.2 million.

Over 180 companies wrote workers' compensation insurance in California in 2002, including the State Compensation Insurance Fund, which is the largest writer in California. Many of our competitors have been in business longer, have a larger volume of business, offer a more diversified line of insurance coverage and have greater financial resources and distribution capability than we do.

Ratings

Financial strength ratings are the opinion of the rating agencies and the significance of individual ratings varies from agency to agency. Companies with higher ratings generally, in the opinion of the rating agency, have the strongest capacity for repayment of debt or payment of claims, while companies at the bottom end of the range have the weakest capacity. Rating agencies continually review the financial performance and condition of insurers. The current financial strength ratings of Sierra's HMO and insurance subsidiaries are as follows:

A.M. Best Company, Inc., "B" (Fair, 7 th of 16); and

Fitch, Inc., "BBB" (Good, 9 th of 23).

Debt ratings are assessments of the likelihood that a company will make timely payments of principal and interest. The principal agencies that rate Sierra's senior convertible debentures are as follows:

Standard and Poors Corp., "B+" (Speculative, 14th of 22); and

Fitch, Inc., "BB" (Speculative, 12 th of 23).

The ratings reflect the opinion of each rating agency, on our operating performance and ability to meet obligations to policyholders and debenture holders, and are not evaluations directed toward the protection of investors in our common stock or senior convertible debentures.

Losses and Loss Adjustment Expenses

All losses and LAE are related to our discontinued workers' compensation operations. In workers' compensation insurance, several years may elapse between the occurrence of a loss and the final settlement of the loss. To recognize liabilities for unpaid losses, we establish reserves, which are balance sheet liabilities representing estimates of future amounts needed to pay claims and related expenses for insured events, including reserves for events that have been incurred but not reported or IBNR.

When a claim is reported, our claims personnel initially establish reserves on a case-by-case basis for the estimated amount of the ultimate payment. These estimates reflect the judgment of the claims personnel based on their experience and knowledge of the nature and value of the specific type of claim and the available facts at the time of

reporting as to severity of injury and initial medical prognosis. Included in these reserves are estimates of the expenses of settling claims, including legal and other fees. Claims personnel adjust the amount of the case reserves as the claim develops and as the facts warrant.

IBNR reserves are established for unreported claims and loss development relating to current and prior accident years. In the event that a claim that occurred during a prior accident year was not reported until the current accident year, the case reserve for the claim typically will be established out of previously established IBNR reserves for that prior accident year. Unallocated loss adjustment expense reserves are established for the estimated costs related to the general administration of the claims adjustment process.

The National Association of Insurance Commissioners requires that we submit a formal actuarial opinion concerning loss reserves with each statutory annual report. The annual report must be filed with each applicable state department of insurance on or before March 1st of the succeeding year. The actuarial opinion must be signed by a qualified actuary as determined by the applicable state insurance regulators. We retain the services of a qualified independent actuary to periodically review our loss reserves. We complied with the actuarial opinion requirement when we filed our 2002 statutory annual reports.

We review the adequacy of our reserves on a periodic basis and consider external forces including changes in the rate of inflation, the regulatory environment, the judicial administration of claims, medical costs and other factors that could cause actual losses and LAE to change. Reserves are reviewed with our independent actuary at least annually and usually twice a year. The actuarial projections include a range of estimates reflecting the uncertainty of projections. We evaluate the reserves in the aggregate, based upon the actuarial indications, and make adjustments where appropriate. Our consolidated financial statements provide for reserves based on the anticipated ultimate cost of losses. We also supplement our analyses by comparing our paid losses and incurred losses to similar data provided by the Workers' Compensation Insurance Rating Bureau of California for all California workers' compensation insurance companies.

Government Regulation and Recent Legislation

HMOs and Managed Indemnity.

Federal and state governments have enacted statutes that extensively regulate the activities of HMOs. Among the areas regulated by federal and state law are the scope of benefits available to members, grievances and appeals, prompt payment of claims, premium structure, enrollment requirements, the relationships between an HMO and its health care providers and members, licensing and financial condition. Government concerns regarding increasing health care costs and quality of care could result in new or additional state or federal legislation that would impact health care companies, including HMOs, PPOs and other health insurers.

Government regulation of health care coverage products and services is a dynamic area of law that varies from jurisdiction to jurisdiction. Amendments to existing laws and regulations are continually being considered and interpretation of the existing laws and rules changes from time to time. Regulatory agencies generally exercise broad discretion in interpreting laws and promulgating regulations to enforce their interpretations.

While we are unable to predict what legislative or regulatory changes may occur or the impact of any particular change, our operations and financial results could be negatively affected by any legislative or regulatory requirements. For example, any proposals to eliminate or reduce the Employee Retirement Income Security Act, or ERISA, which regulates insured and self- insured health care coverage plans offered by employers, pre-emption of state laws that would increase litigation exposure, affect underwriting practices, limit rate increases, require new or additional benefits or affect contracting arrangements (including proposals to require HMOs and PPOs to accept any health care provider willing to abide by an HMO's or PPO's contract terms), may have a material adverse effect on our business. The continued consideration and enactment of "anti-managed care" laws and regulations by federal and state bodies

may make it more difficult for us to manage medical costs and may adversely affect our business and results of operations.

The Secretary of the U.S. Department of Health and Human Services, or HHS, has established a committee on regulatory reform to help guide HHS' efforts to streamline unnecessarily burdensome and inefficient regulations for the Medicare and Medicaid populations, both of which we arrange services for under our managed care programs. The committee put forth recommendations which are being acted upon by the Secretary of HHS and which we are implementing as required.

In addition to changes in existing laws and regulations, we are subject to audits, investigations and enforcement actions. These include possible government actions relating to ERISA, the Federal Employees Health Benefit Plan, or FEHBP, federal and state fraud and abuse laws and laws relating to utilization management and the delivery and payment of health care. In addition, our Medicare business is subject to Medicare regulations promulgated by CMS. Violation of government laws and regulations may result in an assessment of damages, civil or criminal fines or penalties, or other sanctions, including exclusion from participation in government programs. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our reputation in various markets and make it more difficult for us to sell our products and services.

There has been Congressional activity in Washington, D.C. relative to Medicare and the Medicare+Choice programs. During 2002, Congress delayed the "lock-in" requirement until 2005, but failed to take action on adequate financing of the Medicare+Choice program. The "lock- in" provisions were due to become effective January 1, 2002.

We have HMO licenses in Nevada, Texas and Arizona. Our HMO operations are subject to regulation by the Nevada Division of Insurance, the Nevada State Board of Health, the Texas Department of Insurance and the Arizona Department of Insurance. In May 2001, we terminated our HMO operations in Arizona, and in September 2001, we filed a withdrawal plan with the Department of Insurance in Texas to terminate our Texas HMO operations effective on April 17, 2002. As part of the withdrawal plan, we terminated our Texas CMS Medicare+Choice and Federal Employees Health Benefits Program contracts at the end of 2001.

Our HMO is federally qualified under the Federal HMO Act and is subject to the Act and its regulations. In order to obtain federal qualification, an HMO must, among other things, provide its members certain services on a fixed, prepaid fee basis and set its premium rates in accordance with certain rating principles established by federal law and regulation. The HMO must also have quality assurance programs in place with respect to our health care providers. Furthermore, an HMO may not refuse to enroll an employee, in most circumstances, because of a person's health, and may not expel or refuse to re-enroll individual members because of their health or their need for health services.

Our managed indemnity health insurance subsidiary is domiciled and incorporated in California and is licensed in 43 states and the District of Columbia. It is subject to licensing and other regulations of the California Department of Insurance as well as the insurance departments of the other states in which it operates or holds licenses.

Our HMO and health insurance subsidiary insurance premium rate increases are subject to various state insurance department approvals or reviews.

Our Nevada HMO and managed indemnity health insurance subsidiaries currently maintain a home office and a regional home office, respectively, in Las Vegas and, accordingly, are eligible for certain premium tax credits in Nevada. We intend to take all necessary steps to continue to comply with eligibility requirements for these credits. The elimination or reduction of the premium tax credit would have a material adverse effect on our business and results of operations.

Under the "corporate practice of medicine" doctrine, in most states, business organizations, other than those authorized to do so, are prohibited from providing, or holding themselves out as providers of, medical care. Some

states, including Nevada, exempt HMOs from this doctrine. The laws relating to this doctrine are subject to numerous conflicting interpretations. Although we seek to structure our operations to comply with corporate practice of medicine laws in all states in which we operate, there can be no assurance that, given the varying and uncertain interpretations of these laws, we would be found to be in compliance with these laws in all states. A determination that we are not in compliance with applicable corporate practice of medicine laws in any state in which we operate could have a material adverse effect on our business and results of operations if we were unable to restructure our operations to comply with the laws of that state.

Certain Medicare and Medicaid antifraud and abuse provisions are codified at 42 U.S.C. Sections 1320a-7b(b) (the Anti-kickback Statute) and 1395nn (the Stark Amendments). Many states have similar anti-kickback and anti- referral laws. These statutes prohibit certain business practices and relationships involving the referral of patients for the provision of health care items or services under certain circumstances. Violations of the Anti- kickback Statute and the Stark Amendments may result in criminal penalties, civil sanctions, fines and possible exclusion from the Medicare, Medicaid and other federal health care programs. Similar penalties are provided for violation of state anti-kickback and anti-referral laws. HHS has issued regulations establishing and defining "safe harbors" with respect to the Anti-kickback Statute and the Stark Amendments. We believe that our business arrangements and operations are in compliance with the Anti-kickback Statute and the Stark Amendments as defined by the relevant safe harbors. However, there can be no assurance that (i) government officials charged with responsibility for enforcing the prohibitions of the Anti-kickback Statute and the Stark Amendments or Qui Tam relators purporting to act on behalf of the Government will not assert that we, or certain conduct in which we are involved, are in violation of those statutes; and (ii) such statutes will ultimately be interpreted by the courts in a manner consistent with our interpretation.

We participate in a consortium of health plans whose work includes seeking legislative permanency for the Social HMO program. The Social HMO, a Medicare+Choice demonstration program that enables our Nevada HMO to offer extended benefits to seniors, will expire, unless renewed, at the end of 2003. The majority of our Medicare members are enrolled in the Social HMO program and the discontinuation of the program would negatively impact our operating results or financial condition.

HIPAA contains provisions that impact us and will require operational changes as various federal departmental regulations required by the Act are promulgated. With certain conditions imposed, the compliance date of the regulation that establishes standards for electronic transactions and code sets was delayed one year to October 1, 2003. One of the conditions of the delay is that health plans request an extension of time by filing a summary report of their implementation plans with HHS by October 16, 2002. We requested an extension of time by filing a summary report prior to the October deadline. The health information privacy rule component of HIPAA requires compliance by April 14, 2003.

Work is underway to meet the requirements of all HIPAA related regulations impacting us. Failure to comply with the standards and implementation specifications of HIPAA regulations could result in investigation by the Office of Civil Rights of HHS and the imposition of criminal penalties and civil sanctions, including fines. At this time, we cannot quantify the cost of compliance or the impact it will have on our business. There can be no assurance that the costs to implement and to comply will not adversely affect our business and results of operations.

In November 2000, the Department of Labor published the final regulation on ERISA claims procedures, the first major revision of the existing claims procedure requirements since 1977. The regulation applies to all employee benefit plans governed by ERISA, whether the benefits are provided through insurance products or are self-funded. This regulation impacts claims filed for our third party administrator services and fully insured health care products, except Medicaid, Medicare and Federal employees. The effective date of this regulation was delayed from January 1, 2002, to the first plan year after July 1, 2002, but no later than January 1, 2003. We made operational changes to comply with this regulation as of July 1, 2002.

In 1999, the Gramm-Leach-Bliley Financial privacy bill was passed by Congress. This bill required financial institutions to enact financial records privacy standards. Individual states were charged with adopting standards and enforcing these provisions. The Nevada Division of Insurance adopted, regulations on financial privacy in December 2002. These regulations excluded health care and workers' compensation records.

The implementation of the amended Federal Do Not Call List regulation is pending appropriations from Congress. We believe we are in compliance with current requirements and estimate that the cost of compliance with the amended Federal Do Not Call List regulation should be minimal.

In 2001, Congress enacted the USA Patriot Act, which included provisions to prevent money laundering by financial institutions, including insurance companies. The Department of Treasury issued proposed regulations to implement the anti-money laundering provisions that would only affect certain life insurance products. We believe that any compliance activity related to our operations will be minimal.

In December 2002, the Terrorism Reinsurance Act of 2002 was enacted. This Act establishes a temporary federal program that provides for a system of shared public and private compensation for insured commercial property and casualty losses arising from acts of terrorism under the Act. The U.S. Treasury Department has been releasing interim guidance on how an insurer can comply with the provisions of this Act. Our workers' compensation subsidiary believes it is complying with the requirements.

Discontinued Workers' Compensation Operations.

We are subject to extensive governmental regulation and supervision in each state in which we conduct workers' compensation business. The primary purpose of the regulation and supervision is to provide safeguards for policyholders and injured workers rather than protect the interests of shareholders. The extent and form of the regulation may vary, but generally it has its source in statutes that establish regulatory agencies and delegate to the regulatory agencies broad regulatory, supervisory and administrative authority. Typically, state regulations extend to matters such as licensing companies; restricting the types or quality of investments; requiring triennial financial examinations and market conduct surveys of insurance companies; licensing agents; regulating aspects of a company's relationship with its agents; restricting use of some underwriting criteria; regulating premium rates, forms and advertising; limiting the grounds for cancellation or nonrenewal of policies; solicitation and replacement practices; and specifying what might constitute unfair practices.

Typically, states mandate participation in insurance guaranty associations, which assess solvent insurance companies in order to fund claims of policyholders of insolvent insurance companies. Under this arrangement, insurers can be assessed up to 1%, or 2% in certain states, of premiums written for workers' compensation insurance in that state each year to pay losses and LAE on covered claims of insolvent insurers. In certain states, insurance companies are allowed to recoup such assessments from policyholders while several states allow an offset against premium taxes. In California, insurance companies are required to recoup guaranty fund assessments from policyholders. California assessments are recorded as an asset and all other assessments are expensed as incurred.

Starting in 2000, the California Insurance Guarantee Association, or CIGA, issued assessments as a result of the insolvency of the insurers owned by Superior National Insurance Group and other insolvent workers' compensation insurance companies. The assessments are initially made on direct premiums written reported in the prior year and are subsequently adjusted to the actual direct premiums written in the following year. For example, CIGA issued an assessment in 2000 using the 1999 direct premiums written as the initial assessment. We began recouping the assessment on policies effective January 1, 2001. Our initial assessment was adjusted to our actual premiums written during 2001. Any difference between the actual and initial premiums written are either refunded to the member insurer, in the case of lower actual premiums, or an additional assessment imposed, in the case of higher actual premiums. In addition, any excess assessments that we recoup would have to be paid to CIGA. The CIGA assessments are recorded as an asset, which is reduced as we recoup the assessments. On an on-going basis, we evaluate the asset

for impairment. In 2000, CIGA assessed us 1% of the 1999 direct premiums written for $1.2 million. In 2001, CIGA assessed us 2% of the 2000 direct premiums written for $3.1 million. In January 2002, CIGA assessed an additional 2% of the 2000 direct written premiums for $3.1 million. In March 2003, CIGA assessed 2% of the 2001 direct written premiums for $2.7 million. These assessments are being recouped starting with policies effective January 1, 2001 through December 31, 2004. As of December 31, 2002, we have receivables of $5.2 million related to these assessments which are included in the assets of discontinued operations.

There were no assessments by non-California states in 2000 and total assessments by all other states were less than $350,000 in 2001 and $400,000 in 2002. It is likely that guarantee fund assessments related to insolvent workers' compensation insurance companies will continue for the next several years.

General.

Besides state insurance laws, we are subject to general business and corporation laws, federal and state securities laws, consumer protection laws, fair credit reporting acts and other laws regulating the conduct and operation of our subsidiaries.

In the normal course of business, we may disagree with various government agencies that regulate our activities on interpretations of laws and regulations, policy wording and disclosures or other related issues. These disagreements, if left unresolved, could result in administrative hearings and/or litigation. We attempt to resolve all issues with the regulatory agencies, but are willing to litigate issues where we believe we have a strong position. The ultimate outcome of these disagreements could result in sanctions and/or penalties and fines assessed against us. Currently, there are no litigation matters pending with any government agencies.

Deposits.

Our HMO and insurance subsidiaries are required by state regulatory agencies to maintain certain deposits and must also meet certain net worth and reserve requirements. The HMO and insurance subsidiaries, including the discontinued operations, had restricted assets on deposit in various states totaling $33.2 million at December 31, 2002. The HMO and insurance subsidiaries must also meet requirements to maintain minimum stockholders' equity, on a statutory basis, as well as minimum risk-based capital requirements, which are determined annually. Additionally, in conjunction with the exit from the Texas HMO health care market, the Texas Department of Insurance approved a plan of withdrawal and Texas Health Choice, L.C., or TXHC, is now required to maintain deposits and net worth of at least $3.5 million. We believe we are in material compliance with our regulatory requirements.

Dividends.

Our HMO and insurance subsidiaries are restricted by state law as to the amount of dividends or distributions that can be declared and paid. Moreover, insurance companies and HMOs domiciled in Texas, Nevada and California generally may not pay extraordinary dividends or distributions without providing the state insurance commissioner with 30 days prior notice, during which period the commissioner may disapprove the payment. An "extraordinary dividend or distribution" is generally defined as a dividend or distribution whose fair market value together with that of the other dividends or distributions made within the preceding 12 months exceeds the greater of (i) ten percent of the insurer's surplus as of the preceding December 31 or (ii) net gain from operations of an insurer, if a life insurer, or net income if not a life insurer, for the 12-month period ending on the preceding December 31.

In addition, our California domiciled insurance subsidiaries may not pay a dividend without the prior approval of the state insurance commissioner to the extent the cumulative amount of dividends or distributions paid or proposed to be paid in any year exceeds the amount shown as unassigned funds (reduced by any unrealized gains included in any such amount) on the insurer's statutory statement as of the previous December 31.

In 2001, California Indemnity Insurance Company received approval to pay an aggregate of $10.0 million in dividends to CII Financial, all of which was used to purchase or retire CII Financial's then outstanding subordinated debentures. In 2002, California Indemnity Insurance Company paid dividends of $1.5 million. We are not in a position to assess the likelihood of obtaining future approval for the payment of dividends other than those specifically allowed by law in each of our subsidiaries' state of domicile.

No prediction can be made as to whether any legislative proposals relating to dividend rules in the domiciliary states of our subsidiaries will be made or adopted in the future, whether the insurance departments of such states will impose either additional restrictions in the future or a prohibition on the ability of our regulated subsidiaries to declare and pay dividends or as to the effect of any such proposals or restrictions on our regulated subsidiaries.

Employees

We had approximately 3,700 employees as of March 5, 2003. None of our employees are covered by a collective bargaining agreement. We believe that relations with our employees are good.

Other

Our principal executive offices are located at 2724 North Tenaya Way, Las Vegas, Nevada 89128, and our telephone number is (702) 242-7000. Our website is www.sierrahealth.com. We make available free of charge on or through our Internet website our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC.

Forward-Looking Statements

This annual report on Form 10-K contains "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, both as amended.

The forward-looking statements regarding our business and results of operations should be considered by our stockholders or any reader of our business or financial information along with the risk factors discussed below. All statements other than statements of historical fact are forward- looking statements for purposes of federal and state securities laws. The cautionary statements are made pursuant to the "safe harbor" provisions of the Private Securities Litigation Reform Act of 1995, as amended, and identify important factors that could cause our actual results to differ materially from those expressed in any projected, estimated or forward-looking statements relating to us. These forward-looking statements are identified by their use of terms and phrases such as "anticipate," "believe," "could," "estimate," "expect," "hope," "intend," "may," "plan," "predict," "project," "seeks," "will," "continue," and other similar terms and phrases, including references to assumptions. Such forward-looking statements may be contained in the sections "Management's Discussion and Analysis of Financial Condition and Results of Operations" and "Business" among other places.

Some of the things that could cause our actual results to differ substantially from our expectations are:

- loss of healthcare premium revenues due to heightened pricing competition;
- inadequate premium revenues due to heightened competition, miscalculations of underlying healthcare cost inflation, utilization and other factors in our rate filings and in underwriting accounts;
- significant reductions in retaining accounts and members;
- inability or delays in making timely changes to healthcare benefits to offset the impact of inadequate premium rates;
- loss of Medicare, Medicaid or TRICARE contracts;
- our failure to win the competitive procurement for the North Region TRICARE Next Generation contract;
- inability to timely and fairly negotiate TRICARE change orders or contract bid price adjustments with the Department of Defense;
- inability to effectively manage the TRICARE contract and our at-risk members;

- increased charges and losses from the disposition of our workers' compensation insurance business or the inability to dispose of such business at all or on acceptable terms;
- loss of or significant changes in our healthcare provider contracts;
- inability or unwillingness of our contracted providers to provide healthcare services to our members;
- higher than expected medical costs including utilization of services;
- the introduction of new medical technologies and pharmaceuticals;
- higher costs of medical malpractice insurance, increased claims, reduced coverage that increases our risk exposure or the unavailability of coverage that either affects us or our contracted providers;
- unpaid healthcare claims and healthcare costs resulting from insolvencies of providers with whom we have capitated contracts;
- terrorist acts that directly affect the operation of our business or our customers, policyholders and members;
- adverse developments related to our TRICARE contract due to possible military actions in Iraq or elsewhere;
- a sustained economic recession, especially in Nevada;
- adverse loss development on healthcare payables resulting from unanticipated increases or changes in our claims costs;
- adverse legal judgments that are not covered by insurance or that indirectly impact our ability to obtain insurance in the future at reasonable costs;
- significant declines in investment rates;
- inability to implement HIPAA privacy rules or other material regulatory requirements on a timely, accurate and cost effective basis;
- a ratings downgrade from insurance rating agencies, such as A.M. Best Company and Fitch Ratings, and from healthcare quality rating organizations, such as the National Committee for Quality Assurance;
- changes in federal or state tax regulations and laws or programs, including healthcare reform;
- inability to maintain or enhance, as required, our management information systems to ensure, among other things, the timely and accurate billing of premiums and the timely and accurate payment of claims, in compliance with applicable governmental and contractual requirements;
- inability to expand our e-business initiatives on a timely basis and in compliance with government regulations; and
- other factors referenced in this annual report on Form 10-K, including those set forth under the caption "Risk Factors."

Although we believe that the expectations reflected in any of our forward-looking statements are reasonable, actual results could differ materially from those projected or assumed in any of our forward-looking statements.

In making these statements, we disclaim any intention or obligation to address or update each factor in future filings or communications regarding our business or results, and we do not undertake to address how any of these factors may have caused changes to discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected our past results and may affect future results, so that our actual results may differ materially from those expressed here and in prior or subsequent communications.

We urge you to review carefully the section below, "Risk Factors," in this 2002 annual report on Form 10-K for a more complete discussion of the risks associated with an investment in our securities.

Risk Factors

You should carefully consider the following risks, as well as the other information contained in this annual report on Form 10-K. If any of the following risks actually occur, our business could be harmed. You should refer to the other information set forth in this annual report on Form 10-K, including the information set forth in "Forward-Looking Statements," and our consolidated financial statements herein. The information specifically set forth under "Forward-Looking Statements" constitutes additional risks which, if they actually occur, could harm our business as well.

Risks Related to our Continuing Operations

If we fail to win the competitive procurement for the North Region T-Nex contract, our operating results, financial condition and cash flows for future years will be materially adversely affected.

SMHS will complete the last year of a five-year TRICARE contract in May 2003, but it has successfully completed negotiations with the DoD to extend the contract for up to four years at the government's sole option on a year-to-year

basis. SMHS' TRICARE contract accounted for over 29% of revenues in 2002. Based on the government's current time schedule, the T-Nex contracts, which will supercede all outstanding TRICARE contracts, are projected to be awarded in mid-2003. In March 2003, we contributed $35.0 million of the net proceeds of the 2¼% senior convertible debentures to our subsidiary, Sierra Military Health Services Inc., or SMHS, in furtherance of its bid for the T-Nex contract. Sierra will also guarantee SMHS's performance under the T-Nex contract. We are competing, however, with bidders that may have greater financial resources and greater brand recognition than we do for a territory that is significantly larger than the territory we currently serve. Additionally, there are fewer territories available under the new program on which to bid.

Full healthcare services under the T-Nex contract for the North Region are initially anticipated to begin in 2004. We will continue to operate under the current TRICARE Region 1 contract until the government chooses not to exercise the next option year of the contract or exercises its option to terminate this contract, which it can do at its discretion. If the contract is terminated, the contract provides for the payment of certain "wind down" costs that we may incur when the contract ends, but we cannot assure you that this payment will cover all of our "wind down" costs. The failure to obtain the T-Nex North Region contract will materially affect our future financial results. In addition, even if we are awarded the T-Nex contract, changes in the terms and provisions of the contract, as compared to those in the current TRICARE contract, may not be favorable to us. We may also face startup and integration challenges, including the implementation of a new claims payment system, in servicing the larger territory.

On January 29, 2003, SMHS submitted a proposal to the Department of Defense as part of a competitive procurement for the North Region T-Nex contract. This proposal may involve unanticipated costs.

We have estimated the fiscal year 2003 proposal costs as part of a competitive procurement for the T-Nex contract to be between $0.10 to $0.15 per diluted share based on shares outstanding as of December 31, 2002. Based on our experience with our earlier bid for the TRICARE Region 1 contract, we may have to submit more than one revised proposal. The cost estimate does not include unanticipated costs including, but not limited to, the government's request for offerors to submit additional revised proposals or potential litigation costs associated with the government's award of the contract. The occurrence of any of these events may adversely affect our operating results and cash flows. In addition, we have and will continue to incur costs to prepare to implement the T-Nex contract that are based on the assumption that our proposal will be successful. In the event we are not successful in procuring the contract, some or all of these costs will not generate any future revenue or earnings for us.

Our Social HMO Medicare premiums may be reduced and if we are unable to compensate by reducing costs, our financial results would be materially affected.

Our Social HMO program accounted for approximately 24% of our 2002 consolidated revenues from continuing operations. The Centers for Medicare and Medicaid Services, or CMS, recently made a presentation on the Social HMO Medicare program and indicated that they may propose reductions, to be phased in over a seven year period, in the capitation amount paid to HMOs. If this program is reduced or eliminated and if we are unable to compensate by reducing costs, our financial results would be materially adversely impacted.

As a healthcare company, we and our healthcare providers may be subject to increased malpractice costs and claims which could adversely affect our business.

We and our healthcare providers are subject to malpractice claims. We require our healthcare providers to maintain malpractice insurance and we set up reserves with respect to potential malpractice claims. While we do not believe that our uninsured exposure to liabilities resulting from malpractice claims is material, there may in the future be significant malpractice liabilities for which we do not have adequate reserves or insurance coverage, and this insurance may not continue to be available at all or on commercially reasonable terms. In addition, punitive damage awards are generally not covered by insurance.

The state of Nevada is considering alternatives to increase business taxes which could adversely affect our operating results.

The governor for the state of Nevada has proposed to increase the state's tax revenue by approximately $1.1 billion over the next two years. Among the tax increase proposals, which are being considered by the state legislature in its current 2003 biennial session, are increases in the employee head count tax, a business gross receipts tax, a tax on services and increases in property taxes. Should the legislature enact tax increases, our financial results could be adversely affected. Should the legislature fail to enact sufficient tax increases, it could result in a significant reduction in government services, which in turn, could adversely impact employers who purchase health insurance from us or the Medicaid program.

In California and Maryland, various tax increases are also being considered, which would affect our business. There can be no assurance that these tax increases will not have a material adverse effect on our business and results of operations.

If we fail to qualify for the Nevada home office tax credit, our tax costs will increase.

Under existing Nevada law, a 50% premium tax credit is generally available to HMOs and insurers that own and substantially occupy home offices or regional home offices within Nevada. In connection with the settlement of a prior dispute concerning the premium tax credit, the Nevada Department of Insurance acknowledged in November 1993 that our HMO and insurance subsidiaries met the statutory requirements to qualify for this tax credit. We intend to take all necessary steps to continue to comply with these requirements. However, the elimination or reduction of the premium tax credit, or our failure to qualify for the premium tax credit, would have a material adverse effect on our business and results of operations.

Our results of operations could be adversely affected by understatements in our actual liabilities caused by understatements in our actuarial estimates of incurred but not reported claims.

We estimate the amount of our reserves for incurred but not reported, or IBNR, claims primarily using standard actuarial methodologies based upon historical data. These methodologies include, among other factors, the average interval between the date services are rendered and the date claims are received and/or paid, denied claims activity, disputed claims activity, utilization, seasonality patterns and changes in membership. The estimates for submitted claims and IBNR claims liabilities are made on an accrual basis and adjusted retrospectively in future periods as required. These estimates could understate or overstate our actual liability for claims and benefits payable. Any increases to prior estimates could adversely affect our business and results of operations in future periods.

We issued $115.0 million of senior convertible debentures which we may not be able to repay in cash and could result in substantial dilution of our earnings per share.

In March 2003, we issued $115.0 million of 2¼% senior convertible debentures due March 3, 2023. Each $1,000 principal amount of the debentures are convertible into 54.6747 shares of our common stock, prior to March 15, 2023 if (1) the sale price of our common stock issuable upon conversion of the debentures reaches a specified threshold; (2) the debentures are called for redemption; (3) there is an event of default with respect to the debentures; or (4) specified corporate transactions have occurred. The conversion rate may be adjusted in certain circumstances and initially represents a conversion price of $18.29 per share. We may be required to purchase all or some of the debentures on March 15, 2008, 2013 and 2018 or upon a change in control event. In either case, we may choose to pay the purchase price of the debentures in cash or our common stock or a combination of both. We may not have enough cash on hand or have the ability to access cash to pay the debentures if presented or at maturity. In addition, the purchase of the debentures with shares of our common stock or the conversion of the debentures into our common stock could result in a substantial dilution of our earnings per share. We may redeem all or some of the debentures on or after March 20, 2008 for cash.

Our subsidiary, CII Financial Inc., or CII, which is currently classified as a discontinued operation, has outstanding senior debentures that mature before our senior convertible debentures. When CII's senior debentures mature in September 2004, if CII cannot refinance or repay the senior debentures with funds from its insurance subsidiaries, and assuming that we have not yet disposed of CII, Sierra may find it necessary to advance or contribute sufficient funds to CII in order to enable it to repay its senior debentures. Under these circumstances, Sierra may not have sufficient funds to pay our obligation under the senior convertible debentures.

We entered into a new senior secured credit facility which will impose significant operating and financial restrictions on us.

We entered into a new revolving credit facility on March 3, 2003. The new credit agreement provides us with a revolving credit facility of $65.0 million and is secured by guarantees by certain of our subsidiaries and a first priority perfected security interest in (i) all the capital stock of each of our unregulated, material domestic subsidiaries (direct or indirect) as well as all of the capital stock of certain regulated, material domestic subsidiaries and (ii) all other present and future assets and properties of ours and those of our subsidiaries that guarantee our credit agreement obligations (including, without limitation, accounts receivable, inventory, real property, equipment, contracts, trademarks, copyrights, patents, license rights and general intangibles) subject, in each case, to the exclusion of the capital stock of CII Financial, Inc. or any of its subsidiaries and certain other exclusions.

The new revolving credit facility will restrict our ability and the ability of our subsidiaries to dispose of assets, incur indebtedness, incur other liens, make investments, loans or advances, make acquisitions, engage in mergers or consolidations, or make capital expenditures and otherwise restrict certain corporate activities. These covenants may prevent us from pursuing certain business opportunities and taking certain actions. In addition, we will be required to comply with specified financial ratios as set forth in the new credit agreement. A failure to comply with these covenants would be an event of default under the credit agreement. The new revolving credit facility matures on April 30, 2006. We cannot assure you that we will be able to successfully refinance or pay this debt when it matures.

We depend on our management for our success and the loss of our founder, Chairman of the Board and Chief Executive Officer, could have a material adverse effect on our business.

Our success has been dependent to a large extent upon the efforts of Anthony M. Marlon, M.D., our founder, Chairman of the Board and Chief Executive Officer, who has an employment agreement with us. Although we believe that the development of our management staff has made us less dependent on Dr. Marlon, the loss of Dr. Marlon could still have a material adverse effect on our business.

Terrorist attacks, such as the attacks that occurred in New York and Washington, D.C. on September 11, 2001, and other attacks, acts of war or military actions, such as possible military actions in Iraq or elsewhere, may adversely affect our operating results and financial condition.

The attacks of September 11, 2001 have contributed to major instability in the U.S. and other financial markets. These terrorist attacks, the military response and future developments, or other military actions such as the possible military actions in Iraq or elsewhere, may adversely affect prevailing economic conditions and the insurance and reinsurance markets. These developments, depending on their magnitude, could have a material adverse effect on our operating results and financial condition.

Our business is subject to substantial government regulation and the impact of this regulation may increase our exposure to lawsuits and/or penalties or other regulatory actions for non-compliance or may otherwise adversely affect our business.

The healthcare industry in general, and HMOs and health insurance companies, in particular, are subject to substantial federal and state government regulation. These regulations, which may increase our exposure to lawsuits and/or

penalties or other regulatory actions for non-compliance, include, but are not limited to cash reserves; minimum net worth; solvency standards; licensing requirements; approval of policy language and benefits; claims payment practices; mandatory products and benefits; provider compensation arrangements; patient confidentiality; premium rates; changes of control and related party transaction approval requirements; medical management tools; dividend payments; investment and risk restrictions; and periodic examinations by state and federal agencies.

As a result, a portion of our HMOs' and insurance companies' cash is essentially restricted by various state regulatory or other requirements limiting certain of our subsidiaries' cash to use within their current operations. State and federal government authorities are continually considering changes to laws and regulations that may affect us. Additionally, legislators in the states in which we operate continue to face pressure to cut back services and programs in ways that would adversely affect us. Many states in which we operate are currently considering regulations relating to mandatory benefits, provider compensation, disclosure and composition of physician networks. If such regulations were adopted by any of the states in which we operate, our business could be materially adversely affected.

As a result of the continued escalation of healthcare costs and the inability of many individuals to obtain healthcare insurance, numerous proposals relating to healthcare reform have been or others may be introduced in the United States Congress and state legislatures. Any proposals affecting underwriting practices, limiting rate increases, requiring new or additional benefits or affecting contracting arrangements (including proposals to require HMOs and preferred provider organizations, or PPOs, to accept any healthcare providers willing to abide by an HMO's or PPO's contract terms), may make it more difficult for us to control medical costs and could have a material adverse effect on our business.

In addition to applicable laws and regulations, we are subject to various audits, investigations and enforcement actions. These include possible government actions relating to ERISA, which regulates insured and self-insured health coverage plans offered by employers; FEHBP, CMS, which regulate Medicare and Medicaid programs; federal and state fraud and abuse laws; and laws relating to utilization management and the delivery of healthcare and the timeliness of payment or reimbursement. Any such government action could result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including exclusion from participation in government programs. In addition, disclosure of any adverse investigation, audit results or sanctions could negatively affect our reputation in various markets and make it more difficult for us to sell our products and services.

Risks Related to Our Discontinued Operations

We are exploring strategic alternatives to dispose of our workers' compensation insurance business and have reclassified it as a discontinued operation. We have recorded reserves and written down certain assets to their estimated net realizable value upon disposition of this business but the actual disposition could result in additional charges and losses. Alternatively, we may be unable to dispose of this business.

Effective December 31, 2002, in accordance with SFAS No. 144, *"Accounting for the Impairment or Disposal of Long-Lived Assets,"* we have treated our workers' compensation insurance business as a discontinued operation. This business will continue to operate until we dispose of it. We may be forced to record additional charges in connection with the disposition, and we may face additional operating losses due to continuing adverse loss development and/or loss of business from agents or policyholders who do not want to place their insurance with us. Such losses could adversely affect the net sales proceeds that we receive and result in additional losses beyond what we have estimated to be the net realizable value upon disposition. We may also lose key employees as a result of the announcement that could adversely affect CII Financial's operations and make its disposition more difficult. In addition, market conditions in the workers' compensation industry may adversely affect sales proceeds. Alternatively, we may be unable to complete a disposition of this business within the required period. If the disposition cannot be completed within the required period, we may have to report the workers' compensation insurance business as a continuing operation.

CII Financial may not be able to service its debt.

As of December 31, 2002, CII Financial had outstanding indebtedness totaling $31.0 million, consisting of $14.0 million aggregate principal amount of its 9½% senior debentures due September 15, 2004, which is net of $1.0 million in debentures purchased by Sierra and eliminated upon consolidation, and $17.0 million of intercompany promissory notes payable to Sierra. As a holding company, CII Financial is dependent upon dividends from its insurance subsidiaries to service its debt. These insurance subsidiaries are separate and distinct legal entities and have no obligation, contingent or otherwise, to pay any amounts due pursuant to the senior debentures issued by CII Financial, whether by dividends, loans, guarantees or other payments. In addition, the payment of dividends and the making of advances to CII Financial by its subsidiaries are, and will continue to be, subject to statutory and regulatory restrictions. In calendar year 2003, without seeking the prior approval of the California Department of Insurance, California Indemnity Insurance Company, which is its only direct subsidiary, cannot pay dividends to CII Financial.

In 2001, CII Financial exchanged $15.0 million aggregate principal amount of the 9½% senior debentures and $20.0 million in cash for its then outstanding subordinated debentures that were due September 15, 2001. At the time of the exchange, CII Financial did not have sufficient resources to fund the cash portion of the exchange offer. Sierra, while not a guarantor of the subordinated debentures, agreed to loan an aggregate of $17.0 million to CII Financial to fund the cash consideration and the interest and expenses incurred in the exchange offer. Sierra borrowed $7.5 million of the funds that were lent to CII Financial from California Indemnity Insurance Company, a subsidiary of CII Financial.

When the senior debentures mature on September 15, 2004, if CII Financial cannot refinance or repay the senior debentures with funds from its insurance subsidiaries, and assuming we have not yet disposed of CII Financial, Sierra may find it necessary to advance or contribute sufficient funds to CII Financial in order to enable it to repay its senior debentures. In this event, we may be unable to collect the $17.0 million owed to us by CII Financial, although we will still owe California Indemnity Insurance Company the $7.5 million we previously borrowed from it.

CII Financial's reinsurance costs have increased and the amount of coverage has been reduced, which could result in higher retained incurred costs and adversely impact CII Financial.

Following September 11, 2001, the reinsurance market has contracted and reinsurance premium rates have significantly increased while coverage limits have been reduced or eliminated such as future exposure to terrorist acts. If CII Financial is unable to adequately increase its premiums to cover the increase in its reinsurance costs or the increase in risk exposure, CII Financial's operating results and financial condition may be materially affected. This could further complicate our efforts to dispose of our workers' compensation business and CII Financial's ability to refinance or repay its senior debentures in 2004.

A variety of factors beyond CII Financial's control could adversely affect the profitability of its insurance subsidiaries.

The profitability of CII Financial's insurance subsidiaries could be adversely affected by the following:

- loss of premiums due to heightened competition or the announcement that Sierra will treat CII Financial as a discontinued operation;
- inadequate premium rates, especially due to heightened competition, and miscalculations in the underlying loss costs and other factors in CII Financial's rate filings and in underwriting accounts;
- established reserves for submitted claims and incurred but not reported, or IBNR, claims may understate our actual liability for claims and benefits payable;
- increased litigation, medical utilization and administrative burdens, particularly in California;

- terrorist acts that directly affect CII Financial's policyholders or CII Financial's ability to operate its business;
- a sustained and severe economic recession in California which accounts for approximately 69% of CII Financial's premium revenue, or which affects the construction industry, which accounts for approximately 25% of CII Financial's premium revenue;
- adverse loss development resulting from unanticipated increases or changes in CII Financial's claims costs;
- inability or unwillingness of CII Financial's reinsurers to honor their contractual obligations;
- increases in CII Financial's reinsurance costs without a corresponding increase in CII Financial's premium rates;
- inability to maintain CII Financial's reinsurance coverage at all or at cost effective rates;
- declines in investment rates;
- new legislation or regulations, including the impact of new legislation enacted in California in 2002 that increased benefits to injured workers on January 1, 2003, which increase CII Financial's costs without a corresponding increase in premium revenues;
- a ratings downgrade from insurance rating agencies such as A.M. Best Company or Fitch Ratings; or
- power interruptions in California, where CII Financial's main computer systems are located.

We exited the Texas HMO healthcare market and ceased providing coverage on April 17, 2002. We have recorded reserves and accrued expenses for all anticipated exit-related costs but unanticipated expenses could result in additional losses during the run-out period.

We exited the Texas HMO healthcare market and stopped providing healthcare services on April 17, 2002. Unanticipated expenses, primarily related to litigation and provider settlements, could result in additional losses.

ITEM 2. DESCRIPTION OF PROPERTIES

We own approximately 27,000 square feet of space in Las Vegas, Nevada, which houses our in-house print shop operations and information systems data center. We lease office and clinical space in Nevada totaling approximately 408,000 and 322,000 square feet, respectively. HPN and SHL own a 134,000 square foot administrative building as their Las Vegas headquarters, which serves as the home office and a regional home office for our Nevada HMO and health insurance subsidiaries, respectively.

In conjunction with the Kaiser-Texas acquisition, we purchased eight medical and office facilities with approximately 323,000 square feet of clinical facilities and approximately 175,000 square feet of administrative facilities. These buildings are subject to a deed of trust note with an original balance of $35.2 million and a remaining principal balance of $12.7 million at December 31, 2002. Four of the original eight buildings were sold during 2002. The remaining four buildings total approximately 254,000 square feet of clinical space and of this total approximately 113,000 is leased to outside parties. The Texas assets have been written down to their estimated market value and are included in the assets of the discontinued operations. We are actively seeking a buyer for the assets.

The workers' compensation subsidiary is headquartered in Nevada and subleases space from us as well as an additional approximately 63,000 square feet of leased office space in California, Colorado and Texas.

We lease approximately 169,000 square feet of office space in other various states as needed for the SMHS administrative headquarters, TRICARE service centers and other regional operations.

We believe that current and planned clinical space will be adequate for our present needs. However, additional clinical space may be required if membership expands in southern Nevada.

ITEM 3. LEGAL PROCEEDINGS

We are subject to various claims and other litigation in the ordinary course of business. Such litigation includes, but is not limited to, claims of medical malpractice, claims for coverage or payment for medical services rendered to HMO members and claims by providers for payment for medical services rendered to HMO and other members. Some litigation may also include claims for punitive damages that are not covered by insurance. Also included in such litigation are claims for workers' compensation and claims by providers for payment for medical services rendered to injured workers. These actions are in various stages of litigation and some may ultimately be brought to trial. With respect to certain pending actions, we maintain commercial insurance coverage with varying deductibles for which we maintain estimated reserves for our self- insured portion based upon our current assessment of such litigation. Due to recent unfavorable changes in the commercial insurance market, we have, for certain risks, purchased coverage with higher deductibles and lower limits of coverage. In the opinion of management, based on information presently available, the ultimate resolution of these pending legal proceedings should not have a material adverse effect on our financial condition.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

None

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

Market Information

Our common stock, par value $.005 per share (the "Common Stock"), is listed on the New York Stock Exchange under the symbol SIE since April 26, 1994 and, prior to that, had been listed on the American Stock Exchange since our initial public offering on April 11, 1985. The following table sets forth the high and low closing prices for the Common Stock for each quarter of 2002 and 2001.

Period	High	Low
2002		
First Quarter	$13.08	$8.13

Second Quarter	22.35	13.17
Third Quarter	23.50	16.16
Fourth Quarter	20.17	9.93
2001		
First Quarter	$6.70	$3.59
Second Quarter	7.04	4.06
Third Quarter	10.97	6.35
Fourth Quarter	9.75	6.97

On March 17, 2003, the closing sale price of Common Stock was $12.29 per share.

Holders

The number of record holders of Common Stock at March 10, 2003 was 691. Based upon information available to us, we believe there are approximately 6,200 beneficial holders of the Common Stock.

Equity Compensation Plan Information

The following table provides information as of December 31, 2002, regarding outstanding awards and shares remaining available for future issuance under the Company's compensation plans under which equity securities are authorized for issuance (excluding 401(k) plans and similar tax-qualified plans):

Plan Category	(a) Number of securities to be issued upon exercise of outstanding options(1)	(b) Weighted-average exercise price of outstanding options	(c) Number of securitie remaining available f future issuance under compensation plans
	(In thousands, except exercise price)		
Equity compensation plans approved by security holders.....	2,643	$ 8.45	1,
Equity compensation plans not approved by security holders (4).....	3,380	6.18	
Total.....	6,023	$ 7.21	2,

See Note 13 of the Notes to the Consolidated Financial Statements for additional information on our stock based compensation plans.

(1) In addition, a total of 73,000 shares of Common Stock are subject to options assumed by the Company in connection with acquisitions, with a weighted average exercise price of $10.97.

(2) All of the shares available for future issuance include: (i) 1,369,000 shares under the 1995 Long-Term Incentive Plan, as amended and restated, issuable as restricted stock or as a bonus, (ii) 93,000 shares under the 1995 Non-Employee Directors' Stock Plan, as amended and restated, issuable in lieu of directors fees, and (iii) 761,000 shares under the Amended and Restated 1985 Employee Stock Purchase Plan, or ESPP, which may be sold directly to employees at a discount. Shares other than those under the ESPP may also be issued in connection with options, warrants and rights.

(3) Includes 761,000 shares remaining available for future issuance under the ESPP.

(4) The 1995 Long-Term Incentive Plan, or Plan, was approved by shareholders in 1995, with additional shares authorized by shareholders in 1998. Subsequent amendments to the Plan by the Board of Directors reserved additional shares for the Plan, resulting in 3,225,000 shares in column (a) and 802,000 shares in column (c) at December 31, 2002. The Plan is administered by the Compensation Committee of the Board of Directors, which is permitted to delegate authority in limited circumstances. The Plan authorizes grants of incentive and non-qualified stock options, stock appreciation rights, restricted stock, deferred stock, bonus stock (including in lieu of other payment obligations), dividend equivalents, and other stock-based awards. Vesting and forfeiture terms of awards are set by the Committee. To date, the Company has granted primarily options, deferred stock (designated as restricted stock units) under the Plan. Options must have an exercise price of at least 100% of the fair market value of the Common Stock on the grant date, and generally have a term not exceeding ten years. The exercise price may be paid in cash or by surrender of previously acquired shares. Restricted stock and restricted stock units granted under the Plan are generally to be settled only in shares, and are subject to a risk of forfeiture upon termination of employment for a specified period, except more favorable terms apply to termination due to death, disability and in other specified cases. The Plan provides that certain awards will become vested upon a change in control of the Company.

The 1995 Non-Employee Directors' Stock Plan, as amended and restated, was approved by shareholders in 1995. Subsequent amendments to the Plan by the Board of Directors reserved additional shares for the Plan, resulting in 155,000 shares in column (a) and 90,000 shares in column (c) at December 31, 2002. The Plan is administered by the Board of Directors. It authorizes the automatic grant of an option to purchase 7,500 shares to each newly elected non-employee director and thereafter annually to each eligible non-employee director. Options have an exercise price of 100% of the fair market value of the Common Stock on the grant date, and expire at the earlier of ten years after grant, one year after termination of service due to death, disability, or retirement, or six months after other terminations (subject to extension if death occurs during the post-termination exercise period). Options become exercisable 20% per year beginning one year after grant, subject to acceleration in the case of death or disability, at a specified date near an optionee's 75th birthday, or in connection with certain change of control transactions. Options may be exercised after termination only to the extent vested at termination, unless otherwise determined by the Board. The Plan also permits discretionary option grants by the Board, with vesting and forfeiture terms set by the Board. The exercise price may be paid in cash or by surrender of previously acquired shares. The Plan also permits directors to elect to receive fees in the form of unrestricted shares of Common Stock or to defer fees in the form of deferred shares, with the number of such shares or deferred shares calculated by dividing the replaced or deferred fees by the then-fair market value of a share of Common Stock.

Dividends

No cash dividends have been paid on the Common Stock since our inception. We currently do not anticipate paying any cash dividends in the foreseeable future. As a holding company, our ability to service our debt and to declare and pay dividends is dependent upon cash distributions from our operating subsidiaries. The ability of our HMO and our insurance subsidiaries to declare and pay dividends is limited by state regulations applicable to the maintenance of minimum deposits, reserves and net worth. The declaration of any future dividends will be at the discretion of our Board of Directors and will depend on, among other things, future earnings, debt covenants, operations, capital requirements, the tax treatment of dividends, our financial condition and general business conditions. Our new credit agreement restricts our ability to pay dividends.

ITEM 6. SELECTED FINANCIAL DATA

The table below presents our selected consolidated financial information for the years indicated. The table should be read in conjunction with the Consolidated Financial Statements and the related Notes thereto, "Management's Discussion and Analysis of Financial Condition and Results of Operations" and other information which appears elsewhere in this 2002 Form 10-K. The selected consolidated financial data below has been derived from our audited Consolidated Financial Statements. Due to the classification of the workers' compensation operations as discontinued, the amounts presented below were reclassified to conform with the current year presentation.

	Years Ended December			
	2002	2001	2000	
	(In thousands, except per sh			
Statements of Operations Data:				
OPERATING REVENUES:				
Medical Premiums	$ 857,741	$ 718,994	$ 637,769	$
Military Contract Revenues	373,589	338,918	330,352	
Professional Fees	30,923	28,985	33,102	
Investment and Other Revenues	16,382	16,603	18,393	
Total	1,278,635	1,103,500	1,019,616	
OPERATING EXPENSES:				
Medical Expenses	712,290	608,757	576,738	
Military Contract Expenses	360,375	331,621	323,265	
General and Administrative Expenses	133,979	122,623	112,220	
Asset Impairment, Restructuring, Reorganization and Other Costs (1)	--	--	30,836	
Total	1,206,644	1,063,001	1,043,059	
OPERATING INCOME (LOSS) FROM CONTINUING OPERATIONS	71,991	40,499	(23,443)	
Interest Expense	(7,487)	(15,786)	(17,865)	
Other Income (Expense), Net	(108)	(2,071)	1,084	
INCOME (LOSS) FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	64,396	22,642	(40,224)	
(PROVISION) BENEFIT FOR INCOME TAXES	(22,088)	(7,161)	9,205	

INCOME (LOSS) FROM CONTINUING OPERATIONS	42,308	15,481	(31,019)	
(LOSS) INCOME FROM DISCONTINUED OPERATIONS	(5,860)	(11,995)	(168,896)	
NET INCOME (LOSS)	$ 36,448	$ 3,486	$ (199,915)	$
EARNINGS PER COMMON SHARE (2):				
Income (Loss) From Continuing Operations	$ 1.47	$ 0.56	$ (1.15)	$
(Loss) Income from Discontinued Operations	(0.20)	(0.43)	(6.22)	
Net Income (Loss)	$ 1.27	$ 0.13	$ (7.37)	$
Weighted Average Number of Common Shares Outstanding	28,756	27,685	27,142	
EARNINGS PER COMMON SHARE ASSUMING DILUTION (2):				
Income (Loss) From Continuing Operations	$ 1.36	$ 0.54	$ (1.15)	$
(Loss) Income from Discontinued Operations	(0.19)	(0.42)	(6.22)	
Net Income (Loss)	$ 1.17	$ 0.12	$ (7.37)	$
Weighted Average Number of Common Shares Outstanding Assuming Dilution	31,141	28,509	27,142	

	December 31,			
	2002	2001	2000	
			(In thousand	
Balance Sheet Data:				
Working Capital	$ 122,252	$ 65,986	$ 46,201	$
Total Assets	1,065,966	1,064,846	1,162,773	
Long-term Debt (Net of Current Portion)	60,710	163,993	224,970	
Cash Dividends Per Common Share	none	none	none	
Stockholders' Equity	156,565	96,519	90,473	

(1) We recorded certain identifiable asset impairment, restructuring, reorganization and other costs. See Note 16 of the Notes to the Consolidated Financial Statements.

(2) Adjusted to account for three-for-two stock split of our common stock to stockholders of record as of May 18, 1998.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion and analysis provides information which management believes is relevant for an assessment and understanding of our consolidated financial condition and results of operations. The discussion should be read in conjunction with the Consolidated Financial Statements and related Notes thereto. The information contained below may be subject to risk factors. We urge you to review carefully the section "Risk Factors" in this 2002 Form 10-K for a more complete discussion of the risks associated with an investment in our securities. See "Note on Forward-Looking Statements and Risk Factors" under Item 1.

Overview

Our continuing operations derive revenues from our health maintenance organization, managed indemnity plans and military health care services. To a lesser extent, we also derive revenues from non-HMO and insurance products (consisting of fees for workers' compensation third party administration, utilization management services and ancillary products), professional fees (consisting primarily of fees for providing health care services to non-members and co-payment fees received from members), and investment and other revenue.

Our principal expenses consist of medical expenses, military contract expenses, and general and administrative expenses. Medical expenses represent capitation fees and other fee-for-service payments paid to independently contracted physicians, hospitals and other health care providers to cover members, pharmacy costs, as well as the aggregate expenses to operate and manage our wholly owned multi-specialty medical group and other provider subsidiaries. As a provider of health care management services, we seek to positively affect quality of care and expenses by contracting with physicians, hospitals and other health care providers at negotiated price levels, by adopting quality assurance programs, monitoring and managing utilization of physicians and hospital services and providing incentives to use cost-effective providers. Military contract expenses represent payments to providers for health care services rendered under the TRICARE program, as well as administrative costs to operate the military health care subsidiary. General and administrative expenses generally represent operational costs other than those directly associated with the delivery of health care services and military contract services.

Discontinued Operations.

During the third quarter of 2001, we announced our plan to exit the Texas HMO health care market and received formal approval from the Texas Department of Insurance to withdraw our HMO operations in mid-October. We ceased providing HMO health care coverage in Texas on April 17, 2002. As part of our plan to exit Texas, in the third quarter of 2001, we recorded a charge of $17.1 million for premium deficiency costs, the write down of certain assets, legal and restitution costs, and various other exit related costs.

We elected to early adopt Statement of Financial Accounting Standards No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets" or SFAS No. 144, effective January 1, 2001. In accordance with SFAS No. 144, beginning January 1, 2001, our Texas HMO health care operations were reclassified and presented as discontinued operations.

On January 15, 2003, we announced that we were exploring strategic alternatives for our workers' compensation insurance company, CII Financial, Inc., or CII. The alternatives may include a sale, spin-off or management buyout. The disposal of the operations was approved by our Board of Directors on December 31, 2002. Accordingly, beginning in the fourth quarter of 2002, we reclassified our workers' compensation insurance business as discontinued operations. We will continue to operate the business until a disposal occurs.

In conjunction with the decision to dispose of the workers' compensation operations, CII recorded valuation adjustments of $17.3 million, $11.3 million after tax, to reduce this business to its estimated net realizable value upon disposition. The valuation adjustments included the write down of accounts receivable, fixed assets and certain other assets of $4.0 million and additional loss reserves of $8.3 million for the 2002 accident year and $5.0 million for prior accident years.

Critical Accounting Policies and Estimates

Our consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America. In preparing these financial statements, we are required to make judgments, assumptions and estimates, which we believe are reasonable and prudent based on the available facts and circumstances. These judgments, assumptions and estimates affect certain of our revenues and expenses and their related balance sheet accounts and in disclosing our contingent assets and liabilities. We base our assumptions and

estimates primarily on historical experience and trends and factor in known and projected trends. On an on-going basis, we re-evaluate our selection of assumptions and the method of calculating our estimates. Actual results, however, may differ from our calculated estimates and this difference would be reported in our current operations. The following discusses our most critical accounting policies and estimates, which have been reviewed by the Audit Committee of our Board of Directors.

Medical Premiums and Expenses.

Medical premium revenues are recorded in the month when we are obligated to provide services to our enrolled members. Premiums received in advance of the coverage period are recorded as unearned premiums. Our premium revenues are net of an estimate for an allowance for retroactive adjustments. At December 31, 2002, our allowance for retroactive adjustments for health care premium revenues was $3.3 million. Retroactive adjustments result from changes in enrollments that relate to prior periods due to delays in processing or reporting by employers. We use historical trends and known activities to estimate our premium allowances. Any subsequent difference between actual premium adjustments and previously estimated premium adjustments would be reflected in that subsequent year's operating results.

Health care medical expenses are recorded in the period when services are provided to enrolled members, including estimates for provider costs which have been incurred as of the balance sheet date but not yet reported to us. We use a variety of standard actuarial projection methods to make these estimates and we must use our judgment in selecting development factors and assumed trends. In making our projections, we consider medical cost utilization and trends, changes in internal processes, the average interval between the date services are rendered and the date claims are received and/or paid, denied claims activity, disputed claims activity, utilization, seasonality patterns and changes in membership. Our assumptions could be affected by the timing of the receipt of claims, the timing of processing claims and unanticipated changes, such as adverse legal outcomes, legislative or regulatory changes, new interpretations of existing laws or regulations or disputed contract provisions that result in our having to provide new or extended benefits and changes in our health care delivery system or costs. Any subsequent changes in an estimate for a prior year would be reflected in that subsequent year's operating results.

Management believes, based on information presently available, that the recorded liability for medical claims payable, which at December 31, 2002, represented 10.8% of our total consolidated liabilities or $98.0 million, are reasonable and adequate to cover future health care claim payments. However, a difference between the recorded liability and actual developed claim payments could have a material impact to our financial results. For example, a 1% increase in medical claims payable as of December 31, 2002, would reduce reported net income for the year 2002 by $637,000 or 1.75% and diluted earnings per share would be reduced by $0.02.

Military Contract Revenues and Expenses.

Military contract revenue is recorded based on the contract price as agreed to by the federal government. The contract was based on prior years' data provided by the government along with assumptions of future trends. The contract contains provisions that adjust the contract price based on actual experience, which we call the bid price adjustment, or BPA, and for government-directed change orders. For the year ended December 31, 2002, we estimate that approximately $149 million or 40% of the total military contract revenues were for BPA and change orders. At December 31, 2002, military accounts receivable due from the federal government was $47.1 million of which approximately $19.6 million was for accrued BPA and change order revenues. As the data becomes available from the government, we compare the actual results to the contract assumptions and the estimated effects of these adjustments are recognized on a monthly basis. In addition, we record revenue based on estimates of the earned portion of any contract change orders not originally specified in the contract. The BPA and government-directed change orders are subject to negotiation and we must use our judgment in making our estimates. The actual negotiated price could be substantially different from what we had originally estimated. Any subsequent difference would be reported in that subsequent year's operations.

Military contract health care costs are recorded in the period when services are provided to eligible beneficiaries, including estimates for provider costs which have been incurred as of the balance sheet date but not reported to us. We use a variety of actuarial projection methods to make these estimates and we must use our judgment in selecting development factors and assumed trends. Our assumptions, which are in large part related to the same assumptions we use in estimating military contract revenues, could be affected by unanticipated changes, such as new interpretations

of contract provisions that result in our having to provide new or extended benefits and changes in our health care delivery system or costs. We must also factor into our assumptions the limited risk sharing that we have with the government in providing health care services. Any substantial change in our estimates may to a large degree be mitigated by the risk-sharing contract provision. At December 31, 2002, our military health care payable was $65.2 million. Any subsequent changes in an estimate for a prior year would be reflected in that subsequent year's operating results.

Investment Securities.

At December 31, 2002, we had total investments for continuing operations of $200.0 million. All of these investments are classified as available-for-sale and are presented at fair value. Except for restricted cash and investments, which totaled $17.6 million at December 31, 2002, and are reported as non-current assets, the remainder of these investments of $182.4 million are available to support current operations and are therefore reported as current assets.

Our discontinued operations had total investments of $291.5 million of which $286.4 million was classified as available-for-sale and the balance of $5.1 million was classified as held-to-maturity. Held-to-maturity investments are reported at amortized cost because we have the intent and ability to hold these investments until they mature.

Unrealized investment gains and losses, net of related income taxes, on the available-for-sale investments are included as a separate component of stockholders' equity until realized. Realized gains and losses are calculated using the specific identification method and are included in investment and other revenues.

We periodically review our investment portfolio to determine if there is an impairment that is other than temporary. We must use our judgment in testing for impairment and we consider, among other factors, the length of time and the extent of a security's unrealized loss, the financial condition and near term prospects of the issuer, economic forecasts and market or industry trends. If the impairment is determined to be other than temporary, a realized loss is recognized at the date of determination. To date, we have not experienced any significant impairments that were other than temporary in our investments. However, due to the current economic environment and the volatility of the securities market, testing for impairment has become more difficult and there is no assurance that future impairments may not be sustained, which could adversely impact our business and results of operations. For example, if an other than temporary impairment occurred that reduced our investments by 1% at December 31, 2002, our reported net income for the year 2002 would be reduced by $3.2 million or 8.8% and fully diluted earnings per share would be reduced by $0.10.

Litigation and Legal Accruals.

We are subject to various claims and other litigation in the ordinary course of business. Such litigation includes, but is not limited to, claims of medical malpractice, claims for coverage or payment for medical services rendered to HMO members and claims by providers for payment for medical services rendered to HMO and other members. We may also face claims for punitive damages that are not covered by insurance. We are also subject to claims for workers' compensation and claims by providers for payment for medical services rendered to injured workers. With respect to certain pending actions, we maintain commercial insurance coverage with varying deductibles for which we maintain estimated reserves for our self- insured portion based upon our current assessment of such litigation. In addition, we accrue estimated legal defense and other settlement costs based on our assessment of the available information, including our outside legal counsel's assessment of the case. We also assess potential legal exposure, based on the available information, to determine if a precautionary notice of potential claim should be reported to our insurers and if an accrual should be established.

Workers' Compensation Loss and Loss Adjustment Expenses.

Discontinued operations' workers' compensation insurance losses and loss adjustment expenses, or LAE, are based upon the accumulation of cost estimates for reported claims occurring during the period as well as an estimate for losses that have occurred but have not yet been reported. Similar to the health care medical expenses, we use a variety of standard actuarial projection methods to make these estimates and we must use our judgment in selecting development factors and assumed trends. Unlike health care medical expenses, where the cost to provide health care services is substantially completed within one year, workers'

compensation claims can be paid out over a substantial number of years due to certain lifetime benefits. In addition, the period between when a claim is reported to us and when the injury occurred could be longer than one year and when we are no longer insuring the account. Loss and LAE reserves have a significant degree of uncertainty when related to their subsequent payments. Although our reserves are established on the basis of a reasonable estimate, it is not only possible but probable that our reserves will differ from their related subsequent developments. Underlying causes for this uncertainty include, but are not limited to, uncertainty in development patterns, unanticipated inflationary trends affecting the cost of services covered by the insurance contract, adverse legal outcomes and new interpretations of laws or regulations or of disputed contract provisions that result in our having to provide new or extended benefits. This uncertainty can result in both adverse as well as favorable development of actual subsequent activity when compared to the reserve established. During the past four years (1999-2002), we have had adverse development in our previously recorded loss and LAE reserves that has ranged from a low of $8.7 million to a high of $24.0 million. Any subsequent change in loss and LAE reserves established in a prior year would be reflected in that subsequent year's operating results.

Management believes, based on information presently available, that the recorded liability for loss and LAE reserves is reasonable and adequate to cover future workers' compensation claim payments. At December 31, 2002, loss and LAE reserves represented 85.3% of the liabilities of discontinued operations and 47.0% of our total consolidated liabilities. A change between the recorded liability and actual developed claim payments could have a material impact to our business and results of operations. For example, a 1% increase in loss and LAE reserves, not covered by reinsurance, as of December 31, 2002, would reduce reported net income for the year 2002 by $2.8 million or 7.6% and diluted earnings per share would be reduced by $0.09.

Reinsurance Recoverable.

Included in the assets of discontinued operations is reinsurance recoverable, which represents the estimated amount of unpaid workers' compensation loss and LAE reserves that would be recovered from our reinsurers and, to a lesser extent, amounts billed to the reinsurers for their portion of paid losses and LAE. Reinsurance receivable for ceded paid claims is recorded in accordance with the terms of the agreements and reinsurance recoverable for unpaid losses and LAE is estimated in a manner consistent with the claim liability associated with the reinsurance policy. Any significant changes in the underlying claim liability could directly affect the amount of reinsurance recoverable. Reinsurance recoverable, including amounts related to paid and unpaid losses, are reported as assets rather than a reduction of the related liabilities. Reinsurance contracts do not relieve us from our obligations to enrollees, injured workers or policyholders. If our reinsurers were to fail to honor their obligations because of insolvency, disputed contract provisions or for other reasons, we could incur significant losses. Prior to entering into reinsurance contracts, we evaluate the financial condition of our reinsurers to minimize our exposure to significant losses from reinsurer insolvencies. In addition, we periodically monitor the financial strength of our reinsurers to determine if an allowance for uncollectible reinsurance recoverables is warranted. To date, we have never had to write-off a workers' compensation reinsurance recoverable balance and no allowance for uncollectible amounts has been established. At December 31, 2002, reinsurance recoverable for workers' compensation was $189.4 million. Any subsequent change in reinsurance recoverable established in a prior year would be reflected in that subsequent year's operating results.

Management believes, based on information presently available, that the recorded balance for reinsurance recoverables is reasonable and collectible. A change between the recorded balance and the actual developed recoverable could have a material impact to our business and results of operations. For example, a 1% decrease in reinsurance recoverables as of December 31, 2002, would reduce reported net income for the year 2002 by $1.2 million or 3.4% and diluted earnings per share would be reduced by $0.04.

Deferred Tax Assets and Liabilities.

Deferred income tax assets and liabilities result from temporary differences between the tax basis of assets and liabilities and the reported amounts in the consolidated financial statements that will result in taxable or deductible amounts in future years. Our temporary differences arise principally from certain net operating losses, accrued expenses, reserves that are discounted for tax return purposes, depreciation and impairment charges. We regularly review our deferred tax assets for recoverability based on historical taxable income, projected future taxable income and the expected timing of the reversals of the existing temporary differences. A valuation allowance is established for those portions of the deferred tax assets that we consider to be more likely than not unrealizable. At December 31, 2002, our total deferred tax assets, including discontinued operations, was $83.3 million and our total deferred tax liabilities were $1.0 million.

Management believes, based on information presently available, that the recorded deferred tax assets are reasonable and recoverable. A change between the recorded asset and the subsequently used deferred tax asset could have a material impact to our business and results of operations. For example, a 1% decrease in the deferred tax asset as of December 31, 2002 would reduce reported net income for the year 2002 by $833,000 or 2.3% and diluted earnings per share would be reduced by $0.03.

Other.

In addition to the most critical accounting policies and estimates discussed above, other areas requiring us to use judgment, assumptions and estimates include, but are not limited to, workers' compensation earned but unbilled premiums, contractual discounts on professional fee revenue, allowances for doubtful receivables, other accrued liabilities, accrued payroll and taxes, post-employment benefit liabilities, accrued policyholders' dividends, unearned premium revenue and contingent assets and liabilities. For a more extensive discussion of our accounting policies, see Note 2 in the Notes to the Consolidated Financial Statements.

Results of Operations

The following table sets forth selected operating data as a percentage of revenues for the periods indicated:

	Years Ended December 31,		
	2002	2001	2000
OPERATING REVENUES:			
Medical Premiums	67.1 %	65.2 %	62.5 %
Military Contract Revenues	29.2	30.7	32.4
Professional Fees	2.4	2.6	3.2
Investment and Other Revenues	1.3	1.5	1.9
Total	100.0	100.0	100.0
OPERATING EXPENSES:			
Medical Expenses	55.7	55.2	56.6
Military Contract Expenses	28.2	30.0	31.7
General and Administrative Expenses	10.5	11.1	11.0
Asset Impairment, Restructuring, Reorganization and Other Costs	--	--	3.0
Total	94.4	96.3	102.3
OPERATING INCOME (LOSS) FROM CONTINUING OPERATIONS	5.6	3.7	(2.3)
INTEREST EXPENSE	(0.6)	(1.4)	(1.7)
OTHER INCOME (EXPENSE), NET	--	(0.2)	0.1
INCOME (LOSS) FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	5.0	2.1	(3.9)
(PROVISION) BENEFIT FOR INCOME TAXES	(1.7)	(0.7)	0.9
INCOME (LOSS) FROM CONTINUING OPERATIONS	3.3	1.4	(3.0)
LOSS FROM DISCONTINUED OPERATIONS	(0.5)	(1.1)	(16.6)
NET INCOME (LOSS)	2.8 %	0.3 %	(19.6)%

Year Ended December 31, 2002 Compared to 2001

Total Operating Revenues

increased approximately 15.9% to $1.28 billion from $1.10 billion for 2001.

The change in operating revenues was comprised of the following:

- An increase in medical premiums of $138.7 million
- An increase in military contract revenues of $34.7 million
- An increase in professional fees of $1.9 million
- A decrease in investment and other revenues of approximately $200,000

Medical Premiums

from our HMO and managed indemnity insurance subsidiaries increased $138.7 million or 19.3%. The $138.7 million increase in premium revenue reflects a 5.1% increase in Medicare member months (the number of months individuals are enrolled in a plan), a 52.2% increase in Medicaid member months and a 20.4% increase in commercial member months. The growth in Medicare member months contributes significantly to the increase in premium revenues as the Medicare per member premium rates are more than three times higher than the average commercial premium rate.

HMO and POS premium rates for renewing commercial groups increased on average 9% to 12% while the overall rate increase, including continuing business and new members, resulted in an approximate 9.6% increase. Managed indemnity rates increased approximately 10.6%. We did not receive a Medicaid rate increase in 2002 and we do not anticipate one in 2003. The basic Medicare rate increase received in 2002 for the Las Vegas area was approximately 2%. Our overall Medicare rate increase was approximately 6.4% due primarily to the following:

- An increase in the Social HMO membership as a percentage of our total Medicare membership. The Social HMO members have a higher average rate than our other Medicare members. Over 97% of our Las Vegas, Nevada Medicare members are enrolled in the Social HMO Medicare program.
- We experienced increased risk factors in our Social HMO membership which contributes to higher rates and corresponding medical expenses.
- We received rate increases in excess of 2% for membership outside of the Las Vegas area.

The Centers for Medicare and Medicaid Services, or CMS, formerly known as the Health Care Financing Administration, or HCFA, may consider adjusting the reimbursement factor or changing the program for the Social HMO members in the future. At this time, however, the final reimbursement per member for 2004 has not been determined and there is no guaranty that the Social HMO contract will be renewed beyond 2003. It should be noted that Congress has in the past agreed to extend the contract. If the reimbursement for these members decreases significantly and related benefit changes are not made timely, there could be a materially adverse effect on our business. Continued medical premium revenue growth is principally dependent upon continued enrollment in our products and upon competitive and regulatory factors.

Military Contract Revenues

increased $34.7 million or 10.2%. The increase in revenue is primarily the result of additive change order work and is significantly offset by increased military contract expenses associated with those change orders. The Congressionally approved Department of Defense, or DoD, fiscal year 2001 budget included several sweeping changes to the TRICARE program. In April 2001, SMHS began implementation of a prescription drug program for beneficiaries over age 65. Likewise, in October 2001, SMHS implemented TRICARE for Life which is a comprehensive health care benefit to those retired military beneficiaries over age 65. Both of these modifications resulted from Congressional changes to the program. SMHS administers the expanded benefits only to the over age 65 retiree military population. SMHS does not directly fund claims payment or bear any health care underwriting risk on these program modifications for the actual level of health care service utilization and does not record any claim payments or related revenue on these program modifications.

SMHS will complete the last year of a five-year contract in May 2003, but it has successfully completed negotiations with the DoD to extend the contract for up to four years at the government's sole option on a year-to- year basis. The DoD is also currently procuring managed care services under the Next Generation TRICARE contract, or the T-Nex contract, in a combined and larger North Region (covering Michigan, Ohio, Kentucky, Indiana, Illinois, Wisconsin, Virginia and North Carolina in addition to the areas that make up Region 1 which we currently serve). SMHS submitted its bid to the DoD for the T-Nex contract for the North Region on January 29, 2003, with Sierra as a proposed guarantor. The award decision for this contract is initially expected to be made in mid-2003. Once awarded, the new contractor is scheduled to be fully operational in Region 1 by the third quarter of 2004, based on the current timetable set by the DoD, and the new contract would supersede the remainder of the contract extension we have negotiated with the DoD under our current TRICARE Region 1 contract. In March 2003, we contributed $35.0 million of the proceeds of the Sierra Debentures to SMHS in furtherance of its bid for the T-Nex contract.

Professional Fees

increased $1.9 million or 6.7% as a result of higher average co-pays and increased visits at our provider subsidiaries.

Investment and Other Revenues

decreased approximately $200,000 or 1.3% due primarily to a decrease in the average investment yield during the period offset by an increase in the average invested balance. Investment and other revenues now include the revenue associated with administrative services, which were previously reported as part of specialty product revenues.

Medical Expenses

increased $103.5 million or 17.0% due primarily to our increased membership. Medical expenses as a percentage of medical premiums and professional fees decreased to 80.2% from 81.4%. The decrease is primarily due to premium yields in excess of cost and utilization increases which were partially offset by higher bed days in 2002. Our medical claims payable liability requires us to make significant estimates. See the discussion of our medical claims payable liability under critical accounting policies and estimates for a further explanation.

During the third quarter of 2002, the Company entered into a new hospital contract. With this new contract, which began October 1, 2002, the Company holds some form of contracted provider relationship with every hospital in the Las Vegas area.

Military Contract Expenses

increased $28.8 million or 8.7%. The increase is consistent with the increase in revenues discussed previously. Health care delivery expense consists primarily of costs to provide managed health care services to eligible beneficiaries in accordance with Sierra's TRICARE contract. Under the contract, SMHS provides health care services to approximately 678,000 eligible individuals of active duty military personnel, military retirees under the age of 65 and dependents of military retirees through a network of approximately 55,000 health care providers and certain other subcontractor partnerships. Also included in military contract expenses are costs incurred to perform specific administrative services, such as health care appointment scheduling, enrollment, medical and network management services as well as health care advice line services, and other administrative functions of the military health care subsidiary. These administrative services are performed for active duty personnel and family members as well as retired military families.

General and Administrative Expenses,

or G&A, increased approximately $11.4 million or 9.3%. The primary increases in G&A expenses were payroll and benefits, brokers fees, which were primarily due to increased premium revenues, and facility lease expense. The increase in facility lease expense is due to the rent payments associated with the sale- leaseback transaction for our administrative buildings now being recorded as an operating expense. Previously the rent payments were recorded as interest and a reduction of principal and the assets were being depreciated. Our administrative office buildings associated with the sale-leaseback transaction qualified as a sale at the end of the first quarter of 2002. This resulted in a quarterly increase in G&A expenses of approximately $1.1 million and a corresponding decrease in interest expense. See Note 4 of the Notes to the Consolidated Financial Statements for a further explanation of the sale- leaseback transaction. As a percentage of revenues, G&A expenses were 10.5% for 2002, compared to 11.1% in 2001. As a percentage of medical premium revenue, G&A expenses were 15.6% for 2002, compared to 17.1% for 2001. G&A expenses now include the expenses associated with administrative services which were previously reported as part of specialty product expenses.

Interest Expense

decreased $8.3 million or 52.6%. Interest expense related to the revolving credit facility decreased $3.7 million due to a decrease in the average balance of outstanding debt during the period and a decrease in the weighted average cost of borrowing. Our average interest rate on the revolving credit facility, excluding the amortization of deferred financing fees, our interest rate swap agreement and fees on the unused portion of the credit facility was 4.6% in 2002, compared to 8.1% in 2001. We incur a fee of 0.5% on the unused portion of the revolving credit facility. In addition, we are amortizing approximately $300,000 per quarter of deferred financing fees.

Interest expense related to the sale-leaseback transaction decreased by $4.9 million as the remaining buildings qualified as a sale during 2002. See Note 4 of the Notes to the Consolidated Financial Statements for a further explanation of the sale-leaseback transaction. We had various increases in interest expense of approximately $300,000.

Other Income (Expense), Net

increased $2.0 million. We had a net loss on sale of assets of $2.3 million in 2001. In addition, we had an increase between 2002 and 2001 for various other expense items totaling approximately $300,000.

Provision for Income Taxes

was recorded at $22.1 million for 2002 compared to $7.2 million for 2001. The effective tax rate for 2002 was 34.3% compared to 31.6% for 2001. Our ongoing effective tax rate is less than the statutory rate due primarily to tax preferred investments.

Discontinued Operations

consist of our Texas HMO health care operations and the CII workers' compensation operations. The loss from discontinued operations for 2002 was $5.9 million compared to $12.0 million for 2001. The Texas HMO health care operations had a gain of $8.5 million for 2002 which was offset by a loss on the CII workers' compensation operations of $14.3 million.

Discontinued Texas HMO health care operations.

The gain from the Texas HMO health care operations for 2002 included gains, net of tax, related to reserves and accrued liabilities of $5.9 million and to real estate of $2.6 million. During 2002, we had favorable development in both medical claims and legal, restitution and other exit related costs. As a result, we reduced our estimate for medical claims payable by $4.8 million and our legal, restitution and other exit related costs by $4.2 million. The adjustments resulted in income, net of tax, from the discontinued Texas HMO health care operations of $5.9 million.

During 2002, TXHC sold four real estate properties and a piece of land which resulted in a gain, net of tax, on the sale of approximately $700,000. In conjunction with the sales we were required, under the terms of the mortgage loan agreement, to pay pre-determined minimum amounts of the mortgage note. Since the principal payments resulted in a reduction of future interest, future accrued interest was reduced and a gain, net of tax, of $1.9 million was recorded.

Discontinued CII workers' compensation operations.

The discontinued workers' compensation operations for 2002 had a loss of $14.3 million, which included valuation adjustments of $17.3 million, or $11.3 million after tax, to reduce this business to its estimated net realizable value upon disposition. We will continue to operate the business until a disposal occurs.

Net earned premiums increased by $3.0 million or 1.7% due primarily to a decrease in ceded reinsurance premiums of $12.9 million that was partially offset by a $9.9 million decrease in gross earned premiums. Gross written premiums decreased by $10.7 million due primarily to reduced California premium writings. We have been attempting to increase our premium rates, especially in California, where we have experienced significant adverse loss development. In addition, we are becoming more selective in the types of accounts we insure. In 2002, our average premium rate increase on renewing California policies was approximately 37%, which is on top of a 38% average rate increase in 2001. Due to lost business and lower amounts of new business, gross premiums written in California were reduced by $14.1 million. In other states, our average premium rate increase on renewing policies was approximately 8% in 2002 compared to 12% in 2001 and gross premiums written have increased by $3.4 million, primarily in Nevada.

Due to the impact of new legislation in California (see below) and the continuing higher amounts of average incurred claims we have been experiencing, our rate increase in the first two months of 2003 on renewing California policies is approximately 30 - 50%. In addition, we continue to implement stricter underwriting guidelines. This has resulted in a continuation of lost business and lower amounts of new business and our premiums written for the first two months of 2003 in California are down approximately 22% over the comparable 2002 period. Premiums written in our other states are also down by approximately 11%, primarily in Colorado. Premium production results for the first two months of 2003 may not be indicative of the full year's premium production.

Premiums in force are an indicator of future written premium trends and represent the total estimated annual premiums of all policies in force at a point in time. Total inforce premiums decreased by 1% from $168.4 million at December 31, 2001 to $166.9 million at December 31, 2002. As noted above, our premiums written in the first two months of 2003 are significantly reduced from the first two months of 2002. Total inforce premiums at February 28, 2003 are $145.0 million, which represents a reduction of 13.1% from December 31, 2002. At February 28, 2003, premiums in force for California business was reduced by 17.2% to $94.8 million and non-California business was reduced by 4.1% to $50.2 million.

Investment and other revenue decreased by $2.2 million due to a $500,000 investment valuation adjustment and a decrease in the average investment yield during the period offset by an increase in the average invested balance.

Expenses increased in the CII workers' compensation operations by approximately $26.3 million or 14.3%. The increase in expenses is primarily due to the following:

- In conjunction with the decision to dispose of the workers' compensation operations, CII recorded valuation adjustments, which included the write down of accounts receivable, fixed assets and certain other assets of $3.5 million and an increase in loss and LAE reserves of $13.3 million.

- Approximately $2.3 million in additional loss and LAE is related to the increase in net earned premiums in 2002 compared to 2001.

- In 2002, we recorded $24.0 million of net adverse loss development for prior accident years compared to net adverse loss development of $8.7 million recorded in 2001. Of the $24.0 million recorded, $1.4 million is related to our mandatory participation in assumed reinsurance pools and $5.0 million was recorded in conjunction with the valuation adjustments described above. The net adverse loss development recorded was largely attributable to higher costs per claim, or claim severity, in California, primarily on accident years 1996, 1997, 2000 and 2001. Higher claim severity has had a negative impact on the entire California workers'

compensation industry in the past few periods and this trend may continue.

- The loss and LAE ratio for the 2002 accident year was higher by 3.0% which resulted in an increase of approximately $5.3 million in additional losses including the $8.3 million recorded as part of the valuation adjustments. Excluding the valuation adjustment, which represents 4.7% of net earned premiums, the 2002 accident year loss and LAE ratio would have been 1.7% less than the 2001 accident year loss ratio. The decrease is due to the higher premium rates we have been obtaining which were substantially offset by higher estimated average incurred claims.

- The net decrease in underwriting expenses, policyholders' dividends and other operating expenses, excluding the valuation adjustments, was approximately $100,000.

The net adverse loss development on prior accident years included those years that were covered by our low level reinsurance agreement. This resulted in an increase in the reinsurance recoverable balance which is then reduced by amounts collected from reinsurers. During the year ended December 31, 2002, we increased our ceded reserves by $45.9 million and received payments from our reinsurers totaling $74.6 million.

The loss and LAE reserves recorded as of December 31, 2002 reflect our best estimate of the ultimate loss costs for reported and unreported claims occurring in accident year 2002 as well as those occurring in accident years prior to 2002 and are slightly in excess of our independent actuary's point estimate. Workers' compensation claim payments are made over several years from the date of the claim. Until the final payments for reported claims are made, reserves are invested to generate investment income.

The combined ratio is a measurement of the workers' compensation underwriting profit or loss and is the sum of the loss and LAE ratio, underwriting expense ratio and policyholders' dividend ratio. A combined ratio of less than 100% indicates an underwriting profit. Our combined ratio, net of valuation adjustments which represent 9.6%, was 110.0% compared to 106.1% for 2001. The increase was primarily due to increased net adverse loss development for prior accident years. Excluding valuation adjustments and prior accident years' adverse loss development, the combined ratio would have been 99.3% for 2002 and 101.1% for 2001.

In February 2002, California enacted Assembly Bill 749. This new legislation increased benefits paid to injured workers starting January 1, 2003. Increased loss costs, such as benefit increases, are normally built into the rate making process so that premiums are increased to cover the increase in costs. On October 18, 2002, the California Insurance Commissioner approved an increase of 10.5% in pure premium rates for new and renewal policies effective in 2003. In addition, the Commissioner approved a 4.9% increase in pure premium rates for the unexpired terms of policies in force at January 1, 2003. Although we have increased our premiums, there is no assurance that our increase will be sufficient enough to cover the ultimate cost increases or that the estimate of cost increases provided by the Workers' Compensation Insurance Rating Bureau (the organization that accumulates premium and loss data for the State of California for rate making purposes) is accurate. Assembly Bill 749 is effective for claims occurring on and after January 1, 2003. However, due to other statutes, certain temporary total disability claims with dates of injury prior to 2003 will automatically increase to the new benefit levels effective January 1, 2003.

Under our low level reinsurance agreement, we reinsured 30% of the first $10,000 of each claim, 75% of the next $40,000 and 100% of the next $450,000. The maximum net loss retained on any one claim ceded under this agreement was $17,000. This agreement covered all policies in force at July 1, 1998 and continued until June 30, 2000, when we exercised an option to extend coverage to all policies in force as of June 30, 2000. The termination of the low level agreement resulted in our keeping more retained losses and LAE. However, our California premium rates have been increasing, which we believe will largely mitigate the loss of this favorable reinsurance protection. The premium rate increases on policies renewed in California during 2002 and 2001 were approximately 37% and 38%, respectively. For policies effective from July 1, 2000, we obtained excess of loss reinsurance for 100% of the losses above $250,000 and less than $500,000. This agreement terminated on June 30, 2001 and only covered claims with dates of

injury occurring by that date. We already had an existing excess of loss reinsurance agreement that covered 100% of the losses above $500,000. The latter reinsurance agreement is a fixed rate multi-year contract that expired December 31, 2002. We executed an option to extend the coverage for all policies in force as of December 31, 2002 until they expire in 2003.

In the wake of the events of September 11, 2001 and the ensuing hardening of the reinsurance market, our new reinsurance agreements, which cover new and renewal policies effective on and after January 1, 2003, will cost more and has reduced coverage limits, including exclusions for terrorist acts. We continue to retain the first $500,000 per occurrence but the maximum coverage has been reduced from statutory (i.e., unlimited) limits to $20.0 million per occurrence. We also must meet certain annual aggregate deductibles before we can begin to recover from some of our reinsurers. This new coverage will result in our retaining more of the losses and LAE. We have factored these higher costs into our premium rates but there is no assurance that our rates will be adequate to cover these additional costs. The reinsurers on the new agreement consist of domestic as well as foreign reinsurers, and all are rated at least A- or better by A.M. Best Company as of December 31, 2002.

Reinsurance contracts do not relieve us from our obligations to injured workers or policyholders. At December 31, 2002, we had $189.4 million in reinsurance recoverable. We evaluate the financial condition of our reinsurers to minimize our exposure to significant losses from reinsurer insolvencies. We also periodically review the financial strength ratings of our reinsurers to determine if an allowance for uncollectible reinsurance is warranted. As of December 31, 2002 and 2001, no allowance was established. At December 31, 2002, all of our reinsurers were rated AA- and A+ or better by Fitch Ratings and the A.M. Best Company, respectively. Should these companies be unable to perform their obligations to reimburse us for ceded losses, we would experience significant losses.

Year Ended December 31, 2001 Compared to 2000

Total Operating Revenues

for 2001 increased approximately 8.2% to $1.10 billion from $1.02 billion for 2000.

The change in operating revenues was comprised of the following:

- An increase in medical premiums of $81.2 million
- An increase in military contract revenues of $8.6 million
- A decrease in professional fees of $4.1 million
- A decrease in investment and other revenues of $1.8 million

Medical Premiums

from our HMO and managed indemnity insurance subsidiaries increased $81.2 million or 12.7%. The $81.2 million increase in premium revenue reflects a 7.9% increase in Medicare member months (the number of months individuals are enrolled in a plan) and a 10.9% increase in commercial member months. The growth in Medicare member months contributes significantly to the increase in premium revenues as the Medicare per member premium rates are over three times higher than the average commercial premium rate. HMO premium rates for commercial groups increased approximately 6.6%, managed indemnity rates increased approximately 14.6% and Medicare rates increased approximately 4.0%.

Military Contract Revenues

increased $8.6 million or 2.6%. The increase in revenue is primarily the result of additive change order work and is significantly offset by increased military contract expenses associated with those change orders. The Congressionally approved DoD fiscal year 2001 budget included several sweeping changes to the TRICARE program. In April 2001, SMHS began implementation of a

prescription drug program for beneficiaries over age 65 and the implementation of a waiver of co- payments for active duty family members. Both of these program modifications resulted from Congressional changes to the program. Likewise, in October 2001, SMHS implemented TRICARE for Life which is a comprehensive health care benefit to those retired military beneficiaries over age 65. SMHS only administers the expanded benefits to the over age 65 retiree military population.

Professional Fees

decreased $4.1 million or 12.4% due primarily to the closing of our affiliated medical group in Arizona during 2000.

Investment and Other Revenues

decreased $1.8 million or 9.7% due primarily to a decrease in the average investment yield during the period offset by an increase in the average invested balance. Investment and other revenues now include the revenue associated with administrative services which were previously reported as part of specialty product revenues.

Medical Expenses

increased $32.0 million or 5.6%. Excluding the effects of changes in estimate charges for 2000, medical expenses increased approximately $58.0 million or 10.5%. Medical expenses as a percentage of medical premiums and professional fees decreased from 82.1% to 81.4%, excluding changes in estimate charges as described below. The improvement is primarily due to the closing of our rural Nevada clinical operation with a higher medical care ratio and premium yields in excess of cost increases.

Medical expenses reported in 2000 included change in estimate charges of $16.5 million for reserve strengthening primarily due to adverse development on prior years' medical claims and $9.5 million of other non- recurring medical costs primarily relating to the write-down of certain medical subsidiary assets.

Military Contract Expenses

increased $8.4 million or 2.6%. The increase is consistent with the increase in revenues discussed previously. Also included in military contract expenses are costs incurred to perform specific administrative services, such as health care appointment scheduling, enrollment, network management and health care advice line services, and other administrative functions of the military health care subsidiary.

General and Administrative Expenses,

or G&A, increased $10.4 million or 9.3%. As a percentage of revenues, G&A expenses were 11.1% in 2001 compared to 11.0% in 2000. As a percentage of medical premium revenue, G&A expenses were 17.1% for 2001 compared to 17.6% for 2000. G&A expenses now include the expenses associated with administrative services which were previously reported as part of specialty product expenses.

Asset Impairment, Restructuring, Reorganization and Other Costs

for 2000 are discussed below.

Asset Impairments.

Management adopted a plan in the second quarter of 2000 to discontinue medical delivery operations in Mohave County, Arizona and to sell the real estate assets located there, as well as an underperforming medical clinic in Las Vegas. In connection with the restructuring plans adopted and announced by us in the second quarter of 2000, we re-evaluated the recoverability of certain long-lived assets, in accordance with Statement of Financial Accounting Standards No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed Of", or SFAS No. 121, and Accounting Principles Board Opinion No. 17, "Intangible Assets", or APB No. 17, and determined that the carrying values of certain goodwill and other long-lived assets were impaired.

In assessing the asset impairment of the long-lived assets, we first allocated a portion of related goodwill to the fixed assets to be disposed of, in accordance with SFAS No. 121. The fixed assets were then written down to estimated fair

value less costs to sell, which was determined from independent valuations. The remainder of the related goodwill was then assessed for recoverability in accordance with APB No. 17 based on projected discounted cash flows.

The charges recorded for the write-off of goodwill totaled $15.1 million related primarily to the Prime Holdings, Inc. acquisition. The charges recorded for fixed asset impairment totaled $9.5 million for the Arizona and Nevada operations.

Restructuring and Reorganization.

In the second quarter of 2000, we adopted a plan and announced additional restructuring of the Arizona managed health care operations. As a result of this restructuring, we recorded charges in accordance with Emerging Issues Task Force Issue No. 94-3, "Liability Recognition for Certain Employee Termination Benefits and Other Costs to Exit an Activity (Including Certain Costs Incurred in a Restructuring)" of approximately $2.0 million. Of the costs recorded, $1.2 million was for severance, $400,000 was related to clinic closures and lease termination and $400,000 was for other costs.

Other:

The $4.3 million of costs recorded in the second quarter of 2000 relate primarily to an accrual for certain legal settlements as wells as the write-down of certain receivables.

The table below presents a summary of asset impairment, restructuring, reorganization and other costs for the years indicated.

	Asset Impairment	Restructuring and Reorganization	Other	Total
		(In thousands)		
Balance, January 1, 2000	$ --	$ --	$ 3,449	$ 3,449
Charges recorded	24,553	1,983	4,300	30,836
Cash used	--	(1,389)	(302)	(1,691)
Noncash activity	(24,553)	--	(3,000)	(27,553)
Changes in estimate	--	--	--	--
Balance, December 31, 2000	--	594	4,447	5,041
Charges recorded	--	--	--	--
Cash used	--	(594)	--	(594)
Noncash activity	--	--	--	--
Changes in estimate	--	--	--	--
Balance, December 31, 2001	--	--	4,447	4,447
Charges recorded	--	--	--	--
Cash used	--	--	--	--
Noncash activity	--	--	(500)	(500)
Changes in estimate	--	--	--	--
Balance, December 31, 2002	$ --	$ --	$ 3,947	$ 3,947

The remaining other costs of $3.9 million are primarily related to legal claims. Management believes that the remaining reserves as of December 31, 2002 are adequate and that no revisions to the estimates are necessary at this time.

Interest Expense

decreased $2.1 million or 11.6%. Interest expense related to the revolving credit facility decreased $13.3 million due to a decrease in the average balance of outstanding debt during the period and a decrease in the weighted average cost of borrowing. Our average revolving credit facility balance was $61 million in 2001 compared to $183 million in 2000. Our average interest rate on the revolving credit facility, excluding the amortization of deferred financing fees and our interest rate swap agreement was 8.1% in 2001 compared to 9.8% in 2000. The decreases were offset by an increase in interest expense of $9.2 million related to the net financing obligations associated with the sale-leaseback transaction and $2.0 million in other interest expense.

Other Income (Expense), Net

decreased $3.2 million. We had a net loss on sale of assets in 2001 of $2.3 million compared to a gain of $1.2 million in 2000. In addition, we had an increase between 2001 and 2000 for various other income items totaling approximately $300,000.

Provision for Income Taxes

was recorded at $7.2 million for 2001 compared to a tax benefit of $9.2 million for 2000. The effective tax rate for 2001 was 31.6% compared to 22.9% for 2000. The effective tax rate for 2000 reflects the non-deductibility of certain portions of goodwill impairment expense recorded during the period.

Discontinued Operations

consist of our Texas HMO health care operations and the CII workers' compensation operations. The loss from discontinued operations for 2001 was $12.0 million compared to $168.9 million for 2000. The Texas HMO health care operations had a loss of $14.0 million for 2001 compared to a gain of $2.0 million for the CII workers' compensation operations.

Discontinued Texas HMO health care operations.

The 2001 loss includes costs to exit the Texas HMO health care market of $17.1 million offset by various other income from operations. Included in the 2000 loss were the following: (a) asset impairment charges of $126.4 million for impaired goodwill; (b) $36.5 million for impaired real estate and other fixed assets; (c) medical expenses of $14.7 million, primarily for adverse development on prior periods' medical claims; (d) $15.5 million for premium deficiency medical costs; (e) $10.4 million for premium deficiency maintenance costs; and (f) other restructuring, reorganization and other costs of $13.3 million.

Discontinued CII workers' compensation operations.

The discontinued workers' compensation operations for 2001 had a profit of $2.0 million compared to a loss of $7.8 million in 2000. Net earned premiums increased by $47.7 million or 38.0% due primarily to a decrease in ceded reinsurance premiums. Ceded reinsurance premiums decreased as our low level reinsurance agreement expired on June 30, 2000 and was replaced by a new reinsurance agreement with lower ceded premiums.

Expenses increased in the CII workers' compensation operations by approximately $33.0 million or 21.8%. The increase in expenses is primarily due to the following:

- Approximately $32.9 million in additional loss and LAE is related to the increase in net earned premiums in 2001 compared to 2000.

- In 2001, we recorded $8.7 million of net adverse loss development for prior accident years compared to net adverse loss development of $23.3 million recorded in 2000. The net adverse loss development recorded was largely attributable to higher costs per claim, or claim severity, in California. Higher claim severity has had a negative impact on the entire California workers' compensation industry and this trend may continue.

- We established a higher loss and LAE ratio for the 2001 accident year, which has resulted in an increase of approximately $12.5 million. The majority of the increase is due to the termination of the low level reinsurance agreement on June 30, 2000, which results in a higher risk exposure on policies effective after that date and a higher amount of net incurred loss and LAE.

- During the second quarter of 2000, we wrote-off capitalized costs of $3.0 million related to the application development of an information system software project, which was canceled because the vendor was unable to fulfill its contractual obligations. The amounts written off included software and consulting costs of $1.6 million and capitalized internal personnel costs of $1.4 million.

- A net increase in underwriting expenses, policyholders' dividends and other operating expenses of $5.2 million related primarily to the increase in net earned premiums.

The combined ratio is a measurement of the workers' compensation underwriting profit or loss and is the sum of the loss and LAE ratio, underwriting expense ratio and policyholders' dividend ratio. A combined ratio of less than 100% indicates an underwriting profit. Our combined ratio was 106.1% in 2001 compared to 115.8% for 2000. The decrease was primarily due to significantly higher prior year adverse loss development recorded during 2000. Excluding adverse loss development, the combined ratio would have been 101.1% for 2001 and 97.3% for 2000. The increase in the accident year loss and LAE ratio was primarily due to the run off of the low level reinsurance, which resulted in our retaining more of the incurred losses. The underwriting expense ratio decreased primarily due to higher retained net earned premiums.

LIQUIDITY AND CAPITAL RESOURCES

We had cash flows from operating activities for continuing operations of $136.6 million for the year ended December 31, 2002 compared to $98.2 million in 2001. We used the majority of the cash flow for the purchase of investments and for reductions of debt. Overall, discontinued operations used cash of $47.9 million in 2002 compared to $46.0 million in 2001. Excluding cash used to purchase investments, discontinued operations used cash of $700,000 in 2002 compared to $14.1 million in 2001. The improvement in continuing operations over 2001 is primarily attributable to cash from earnings and the change in assets and liabilities.

The cash flow resulting from the change in assets and liabilities of $72.6 million was primarily due to the following:

- a source of cash due to the decrease in the deferred tax asset balance of $37.9 million

- a source of cash due to the increase in medical claims payable of $16.4 million

- a source of cash due to the increase in other liabilities of $15.0 million

- a source of cash due to the increase in other current liabilities of $14.7 million

- a source of cash due to the decrease in other current assets of $6.5 million

- a use of cash due to the decrease in military health care payable balance of $12.0 million

- a use of cash due to the increase in the military accounts receivable balance of $7.0 million

- various other changes in assets and liabilities accounting for the remaining source of cash of $1.1 million

SMHS receives monthly cash payments equivalent to one-twelfth of its annual contractual price with the Department of Defense, or DoD. SMHS accrues health care revenue on a monthly basis for any monies owed above its monthly cash receipt based on the number of at-risk eligible beneficiaries and the level of military direct care system utilization. The contractual bid price adjustment, or BPA, process serves to adjust the DoD's monthly payments to SMHS, because the payments are based in part on 1996 DoD estimates for beneficiary population and beneficiary population baseline health care cost, inflation and military direct care system utilization. As actual information becomes available for the above items, quarterly adjustments are made to SMHS' monthly health care payment in

addition to lump sum adjustments for past months. In addition, SMHS accrues change order revenue for DoD directed contract changes. As a result of preliminary data accumulated from the BPA process in the last quarter of 2002, SMHS will receive an upward adjustment in 2003 of approximately $3.3 million to its monthly DoD payments starting January 2003. Our business and cash flows could be adversely affected if the timing or amount of the BPA and change order reimbursements vary significantly from our expectations.

On November 16, 2001, SMHS entered into a securitization arrangement with General Electric Capital Corporation. The arrangement provides for the assignment of SMHS' Federal Government accounts receivable to SMHS Funding. SMHS Funding is a special purpose limited liability company owned by SMHS and was formed for the purpose of purchasing all receivables of SMHS. This entity is fully consolidated into SMHS. SMHS Funding may assign an undivided interest in certain of the receivables to a subsidiary of General Electric Capital Corporation in the event that additional financing by SMHS is warranted. This securitization arrangement was not utilized in 2002 and we do not anticipate utilizing it in 2003. See Note 2 of the Notes to the Consolidated Financial Statements.

In the event SMHS wins the competitive procurement for the North Region T-Nex contract, SMHS has received a commitment from General Electric Capital Corporation to provide a $200.0 million senior secured revolving credit facility to support SMHS' additional working capital needs and to refinance its existing securitization agreement.

Net cash used from continuing operations for investing activities during 2002 included $12.4 million in capital expenditures associated with the continued implementation of new computer systems, leasehold improvements on facilities and furniture, equipment and other capital purchases to support our growth. This was offset by net proceeds of $680,000 from property and equipment dispositions. The net cash change in investments for the year was an increase in investments of $135.0 million as investments were purchased with available funds.

Cash used in financing activities during 2002 included payments of $30.4 million on debt related items offset by $16.9 million in proceeds received from the sale-leaseback notes and $10.2 million in cash received related to the sale of stock through our employee stock purchase plan and stock option plans. The year 2001 included net proceeds from long-term borrowings (proceeds less payments) of $53.2 million and proceeds of $2.1 million related to the sale of stock through our employee stock purchase plan.

On December 28, 2000, we sold the majority of our Las Vegas, Nevada administrative and medical clinic real estate holdings in a sale-leaseback transaction. As part of the transaction, we financed a portion of the sales price with mortgage notes receivable of $22.2 million and provided deposits of $4.3 million. In accordance with Statement of Financial Accounting Standards No. 98, "Accounting for Leases", or SFAS No. 98, we recorded the transaction as a financing obligation of $113.7 million offset by the mortgage notes receivable of $22.2 million. As of September 30, 2002, we had received the deposits back and full payment of the outstanding mortgage obligations. The payments cured the continuing involvement criteria from SFAS No. 98 and the transaction then qualified as a sale. See Note 4 of the Notes to the Consolidated Financial Statements for a further explanation.

Sierra Debentures

In March 2003, we issued $115.0 million aggregate principal amount of 2¼% senior convertible debentures due March 15, 2023. We used the net proceeds of the offering to repay the $39.0 million outstanding under our existing credit facility and to contribute $35.0 million to SMHS in furtherance of its bid for the TRICARE Next Generation contract. We also used $19.9 million of the proceeds to purchase 1.6 million shares of our common stock under our repurchase program. The remainder of the net proceeds will be used for working capital and general corporate purposes, including, subject to board approval, additional share repurchases.

The debentures are convertible, at the option of the holders, into shares of Sierra Health Services, Inc. common stock at a conversion price of $18.29, upon certain conditions including the sale price of Sierra's common stock exceeding 120% of the conversion price at specified times. The debentures are puttable to us for cash or Sierra common stock, at

our election, on March 15 in 2008, 2013 and 2018 and upon certain corporate events including a change in control. The debentures can be called for cash beginning on March 20, 2008.

New Credit Facility

On March 3, 2003, we entered into a new $65.0 million revolving credit facility which replaces the amended and restated credit facility. The new facility may be increased up to an aggregate amount of $125.0 million upon receipt of new commitments from existing or additional lenders. Interest on the facility is initially LIBOR plus 2.25%. The facility will expire on April 30, 2006 but can be extended, at the sole discretion of each of the lenders, until March 3, 2008. The new facility is available for general corporate purposes.

The new credit facility is secured by guarantees by certain of our subsidiaries and a first priority perfected security interest in (i) all the capital stock of each of our unregulated, material domestic subsidiaries (direct or indirect) as well as all of the capital stock of certain regulated, material domestic subsidiaries and (ii) all other present and future assets and properties of ours and those of our subsidiaries that guarantee our credit agreement obligations (including, without limitation, accounts receivable, inventory, real property, equipment, contracts, trademarks, copyrights, patents, license rights and general intangibles) subject, in each case, to the exclusion of the capital stock of CII Financial, Inc. or any of its subsidiaries and certain other exclusions.

The new revolving credit facility has covenants that restrict our ability and the ability of our subsidiaries to dispose of assets, incur indebtedness, incur other liens, make investments, loans or advances, make acquisitions, engage in mergers or consolidations, or make capital expenditures and otherwise restricts certain corporate activities. In addition, we will be required to comply with specified financial ratios as set forth in the new credit agreement.

CII Financial Senior Debentures

At September 30, 2000, CII Financial, Inc., currently part of our discontinued operations, had approximately $47.1 million of subordinated debentures that were due on September 15, 2001. These subordinated debentures were neither assumed nor guaranteed by Sierra and were subordinated to Sierra's credit facility debt. In December 2000, CII Financial commenced an offer to exchange the subordinated debentures for cash and/or new debentures. On May 7, 2001, CII Financial closed its exchange offer on $42.1 million of its outstanding subordinated debentures. CII Financial purchased $27.1 million in principal amount of subordinated debentures for $20.0 million in cash and issued $15.0 million in new 9½% senior debentures, due September 15, 2004, in exchange for $15.0 million in subordinated debentures. The transaction was accounted for as a restructuring of debt; therefore all future cash payments, including interest, related to the debentures will be reductions of the carrying amount of the debentures and no future interest expense will be recognized. Accordingly, the new 9½% senior debentures have a carrying amount of $16.8 million consisting of principal of $14.0 million and $2.8 million in future accrued interest. Since the time of the exchange and as of December 31, 2002, Sierra has purchased $1.0 million in outstanding 9½% senior debentures which are eliminated upon consolidation.

To facilitate the exchange offer, Sierra lent CII Financial $17.0 million, of which $7.5 million was borrowed from California Indemnity Insurance Company, a wholly-owned subsidiary of CII Financial. In addition, California Indemnity received approval from the California Department of Insurance to pay a dividend of $15.0 million to CII Financial. In September 2001, California Indemnity received approval from the California Department of Insurance to pay an additional $5.0 million dividend to CII Financial, which was used to pay the remaining subordinated debentures that matured on September 15, 2001.

The new 9½% senior debentures pay interest, which is due semi-annually on March 15 and September 15 of each year, commencing on September 15, 2001. The new 9½% senior debentures rank senior to outstanding notes payable from CII Financial to Sierra and CII Financial's guarantee of Sierra's revolving credit facility. The new 9½% senior debentures may be redeemed by CII Financial at any time at premiums starting at 110% and declining to 100% for

redemptions after April 1, 2004. In the event of a change in control of CII Financial, the holders of the new 9½% senior debentures may require that CII Financial repurchase them at the then applicable redemption price, plus accrued and unpaid interest.

CII is a holding company and its only significant asset is its' investment in California Indemnity. Of the $23.1 million in cash and cash equivalents it held at December 31, 2002, approximately $21.5 million was designated for use only by the regulated insurance companies. CII has limited sources of cash and is dependent upon dividends paid by California Indemnity. California Indemnity may only pay a dividend without the prior approval of the state insurance commissioner to the extent the cumulative amount of dividends or distributions paid or proposed to be paid in any year does not exceed the amount shown as unassigned funds (reduced by any unrealized gains or losses included in any such amount) on its statutory statement as of the previous December 31. In 2003, California Indemnity cannot pay dividends without the prior approval of the state insurance commissioner. In 2002 California Indemnity paid a total of $1.5 million in dividends. We are not in a position to assess the likelihood of obtaining future approval for the payment of dividends other than those specifically allowed by law in each of our subsidiaries' state of domicile.

Sierra Share Repurchase Program

On January 7, 2003, we announced that our Board of Directors authorized a program for the repurchase of up to 2.0 million shares of our common stock. On February 25, 2003, we announced that we had repurchased approximately 600,000 shares of our common stock and that our Board of Directors had authorized us to purchase up to an additional 600,000 shares under our share repurchase program. Such purchases have been made from time to time at prevailing prices in the open market, by block purchase or in private transactions. As of March 6, 2003, we had purchased a total of 2.2 million shares for $27.6 million.

Statutory Capital and Deposit Requirements

Our HMO and insurance subsidiaries are required by state regulatory agencies to maintain certain deposits and must also meet certain net worth and reserve requirements. The HMO and insurance subsidiaries, including the discontinued operations, had restricted assets on deposit in various states totaling $33.2 million at December 31, 2002. The HMO and insurance subsidiaries must also meet requirements to maintain minimum stockholders' equity, on a statutory basis, as well as minimum risk-based capital requirements, which are determined annually. Additionally, in conjunction with the Kaiser-Texas acquisition, TXHC entered into a letter agreement with the Texas Department of Insurance whereby TXHC agreed to maintain a net worth of $20.0 million, on a statutory basis, until certain income levels were achieved. In conjunction with the exit from the Texas HMO health care market, the Texas Department of Insurance approved a plan of withdrawal and TXHC is now required to maintain deposits and net worth of at least $3.5 million. We believe we are in material compliance with our regulatory requirements.

Of the $68.8 million in cash and cash equivalents held at December 31, 2002, including discontinued operations, $23.0 million was held by discontinued operations and of the remainder, $11.7 million, was designated for use only by the regulated subsidiaries. Amounts are available for transfer to the holding company from the HMO and insurance subsidiaries only to the extent that they can be remitted in accordance with the terms of existing management agreements and by dividends. The holding company will not receive dividends from its regulated subsidiaries if such dividend payment would cause violation of statutory net worth and reserve requirements.

Obligations and Commitments

The following schedule represents our obligations and commitments for long-term debt, capital leases and operating leases at December 31, 2002. With the exception of our amended and restated revolving credit facility, the amounts below represent the entire payment, principal and interest, on our outstanding obligations. The outstanding balance of the amended and restated revolving credit facility is $60 million as of December 31, 2002. The amount has been reflected as due in 2006 as the credit facility was refinanced and terminated in conjunction with the issuance of the

Sierra Debentures and the new $65 million credit facility on March 3, 2003.

	Long-Term Debt	Capital Leases	Operating Leases	Total
			(In thousands)	
Continuing Operations				
Payments due in less than 1 year....	$ 98	$ 121	$ 18,428	$ 18,647
Payments due in 1 to 3 years.....	71	114	34,980	35,165
Payments due in 4 to 5 years.....	60,071	62	32,805	92,938
Payments due after 5 years.....	362	153	123,420	123,935
Total Continuing Operations....	$ 60,602	$ 450	$ 209,633	$ 270,685
Discontinued Operations				
Payments due in less than 1 year....	$ 3,954	$ 235	$ 422	$ 4,611
Payments due in 1 to 3 years.....	20,408	--	69	20,477
Payments due in 4 to 5 years.....	7,364	--	--	7,364
Payments due after 5 years.....	--	--	--	--
Total Discontinued Operations..	$ 31,726	$ 235	$ 491	$ 32,452

Included in long-term debt payments for discontinued operations is a mortgage loan secured by certain underlying real estate assets of the discontinued operations of $15.0 million and the CII Senior Debentures of $16.8 million. We are actively seeking a buyer for the real estate assets and anticipate selling them by the end of 2003. As the assets are sold, we are required to make reductions on the mortgage note and completely satisfy the obligation once all of the assets have been sold.

Other

We have a 2003 capital budget of $30.9 million and are also limited in the amount of capital expenditures we can make by our new revolving credit facility. The 2003 planned expenditures are primarily for a new medical clinic, the purchase of computer hardware and software, furniture and equipment and other normal capital requirements. Our liquidity needs over the next 12 months will primarily be for the capital items noted above, debt service and funds required to exit the Texas HMO health care market. We believe that our existing working capital, operating cash flow and, if necessary, equipment leasing, divestitures of certain non-core assets and amounts available under our credit facility should be sufficient to fund our capital expenditures and debt service. Additionally, subject to unanticipated cash requirements, we believe that our existing working capital and operating cash flow should enable us to meet our liquidity needs on a long-term basis.

We have a $25.0 million interest-rate swap agreement that allows us to mitigate the risk of interest rate fluctuation on our credit facility. The original intent of the agreement was to keep our interest rate on $25.0 million of the credit facility relatively fixed. In accordance with Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities," we recorded the interest- rate swap agreement at its fair value as of December 31, 2002. The fair value indicated that we would need to pay $645,000 to terminate the swap agreement. If the prime rate were to decrease by 1%, we estimate our maximum increase in annual expense associated with the swap to be approximately $250,000.

In the second quarter of 1997, our Board of Directors authorized a $3.0 million loan from us to our Chief Executive Officer, or CEO. In April 2000, our Board of Directors authorized an additional $2.5 million loan from us to our CEO. In the second quarter of 2001, our Board of Directors approved a loan amendment which extended the maturity of the

principal balance along with accrued interest to December 31, 2003. During 2002 and 2001, our CEO made payments of $1.0 million and $898,000, respectively. As of December 31, 2002, the aggregate principal balance outstanding and accrued interest for both instruments was $4.2 million. All amounts borrowed bear interest at a rate equal to the rate at which we could have borrowed funds under our revolving credit facility at the time of the borrowing plus 10 basis points. The amounts outstanding are collateralized by certain of the CEO's assets and rights to compensation from us.

Inflation

Health care costs continue to rise at a rate faster than the Consumer Price Index. We use various strategies to mitigate the negative effects of health care cost inflation, including setting commercial premiums based on our anticipated health care costs, risk-sharing arrangements with our various health care providers and other health care cost containment measures including member co-payments. There can be no assurance, however, that in the future, our ability to manage medical costs will not be negatively impacted by items such as technological advances, competitive pressures, applicable regulations, increases in pharmacy costs, utilization changes and catastrophic items, which could, in turn, result in medical cost increases equaling or exceeding premium increases.

Government Regulation

Our business, offering health care coverage, health care management services, workers' compensation programs and, to a lesser extent, the delivery of medical services, is heavily regulated at both the federal and state levels.

Government regulation of health care coverage products and services is a dynamic area of law that varies from jurisdiction to jurisdiction. Amendments to existing laws and regulations are continually being considered and interpretation of the existing laws and rules changes from time to time. Regulatory agencies generally exercise broad discretion in interpreting laws and promulgating regulations to enforce their interpretations.

While we are unable to predict what legislative or regulatory changes may occur or the impact of any particular change, our operations and financial results could be negatively affected by any legislative or regulatory requirements. For example, any proposals to eliminate or reduce the Employee Retirement Income Security Act, or ERISA, which regulates insured and self-insured health care coverage plans offered by employers, pre-emption of state laws that would increase litigation exposure, affect underwriting practices, limit rate increases, require new or additional benefits or affect contracting arrangements (including proposals to require HMOs and PPOs to accept any health care provider willing to abide by an HMO's or PPO's contract terms) may have a material adverse effect on our business. The continued consideration and enactment of "anti-managed care" laws and regulations by federal and state bodies may make it more difficult for us to manage medical costs and may adversely affect financial results.

In addition to changes in existing laws and regulations, we are subject to audits, investigations and enforcement actions. These include possible government actions relating to ERISA, the Federal Employees Health Benefit Plan, or FEHBP, federal and state fraud and abuse laws and laws relating to utilization management and the delivery and payment of health care. In addition, our Medicare business is subject to Medicare regulations promulgated by CMS. Violation of government laws and regulations may result in an assessment of damages, civil or criminal fines or penalties, or other sanctions, including exclusion from participation in government programs. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our reputation in various markets and make it more difficult for us to sell our products and services.

In addition to the items described above, we urge you to review carefully the section "Risk Factors" in this 2002 Form 10-K for a more complete discussion of the risks associated with an investment in our securities. See "Note on Forward-Looking Statements and Risk Factors" under Item 1.

Recently Issued Accounting Standards

In November 2002, the FASB issued Interpretation No. 45, "Guarantor's Accounting and Disclosure Requirements for Guarantees", or FIN 45. FIN 45 requires a guarantor to recognize, at the inception of a guarantee, a liability for the fair value of the obligation it has undertaken in issuing the guarantee. We will apply FIN 45 to guarantees, if any, issued after December 31, 2002. We do not expect the adoption of FIN 45 to have a material effect on our consolidated financial position or results of operations.

In January 2003, the FASB issued Interpretation No. 46, "Consolidation of Variable Interest Entities", or FIN 46. FIN 46 requires an investor with a majority of the variable interests in a variable interest entity to consolidate the entity and also requires majority and significant variable interest investors to provide certain disclosures. A variable interest entity is an entity in which the equity investors do not have a controlling interest or the equity investment at risk is insufficient to finance the entity's activities without receiving additional subordinated financial support from the other parties. We do not expect the adoption of FIN 46 to have a material effect on our consolidated financial position or results of operations.

In April 2002, the FASB issued Statement of Financial Accounting Standards No. 145, "Recission of FASB Statements No. 4, 44, and 64, Amendment of FASB Statement No. 13, and Technical Corrections", or SFAS No. 145. SFAS No. 145 requires that gains and losses from extinguishment of debt be classified as extraordinary items only if they meet the criteria in Accounting Principles Board Opinion No. 30 ("Opinion No. 30"). Applying the provisions of Opinion No. 30 will distinguish transactions that are part of an entity's recurring operations from those that are unusual and infrequent that meet the criteria for classification as an extraordinary item. SFAS No. 145 is effective for us beginning January 1, 2003. We do not expect the adoption of SFAS No. 145 to have a material effect on our consolidated financial position or results of operations.

In June 2002, the FASB issued Statement of Financial Accounting Standards No. 146, "Accounting for Costs Associated with Exit or Disposal Activities", or SFAS No. 146. SFAS No. 146 addresses financial accounting and reporting for costs associated with exit or disposal activities and nullifies Emerging Issues Task Force Issue No. 94-3, "Liability Recognition for Certain Employee Termination Benefits and Other Costs to Exit an Activity (including Certain Costs Incurred in a Restructuring)". SFAS No. 146 requires that a liability for a cost associated with an exit or disposal activity be recognized when the liability is incurred. A fundamental conclusion reached by the FASB in this statement is that an entity's commitment to a plan, by itself, does not create a present obligation to others that meets the definition of a liability. SFAS No. 146 also establishes that fair value is the objective for initial measurement of the liability. The provisions of this statement are effective for exit or disposal activities that are initiated after December 31, 2002, with early adoption encouraged. We did not elect to early adopt SFAS No. 146 nor do we expect the adoption to have a material effect on our consolidated financial position or results of operations.

In December 2002, the FASB issued Statement of Financial Accounting Standards No. 148, "Accounting for Stock-Based Compensation - Transition and Disclosure", or SFAS No. 148. SFAS No. 148 is an amendment of Statement of Financial Accounting Standards No. 123. SFAS No. 148 provides alternative methods of transition for a voluntary change to the fair value based method of accounting for stock-based employee compensation. In addition, SFAS 148 requires prominent disclosures in interim as well as annual financial statements about the method of accounting for stock-based employee compensation and the effect of the method used on reported net income. The disclosure requirements of SFAS No. 148 are effective for fiscal years ended after December 15, 2002. We have not yet determined if we will implement the voluntary change to the fair value based method of accounting as allowed under SFAS No. 148 for 2003.

ITEM 7a. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are exposed to market risk for the impact of interest rate changes and changes in the market value of our investments. We have not utilized derivative financial instruments in our investment portfolio.

Our exposure to market risk for changes in interest rates relates primarily to our investment portfolio and our long-term debt. As of December 31, 2002, including discontinued operations, we have approximately $560.3 million in cash and cash equivalents and current, long-term and restricted investments. Of the investments, approximately $486.4 million are classified as available-for-sale and $5.1 million are classified as held-to-maturity. These investments are primarily in fixed income, investment grade securities. Our investment policy emphasizes return of principal and liquidity and is focused on fixed returns that limit volatility and risk of principal. Because of our investment policies, the primary market risk associated with our portfolio is interest rate risk.

Assuming interest rates were to increase by a factor of 1.1, the net hypothetical loss in fair value of stockholders' equity related to financial instruments is estimated to be approximately $5.1 million after tax (3.2% of total stockholders' equity). Of the $5.1 million decrease, $4.1 million is related to our discontinued operations. We believe that such an increase in interest rates would not have a material impact on future earnings or cash flows, as it is unlikely that we would need or choose to substantially liquidate our investment portfolio.

The effect of interest rate risk on potential near-term net income, cash flow and fair value was determined based on commonly used interest rate sensitivity analyses. The models project the impact of interest rate changes on a wide range of factors, including duration and prepayment. Fair value was estimated based on the net present value of cash flows or duration estimates, assuming an immediate 10% increase in interest rates. Because duration is estimated, rather than a known quantity, for certain securities, other market factors may impact security valuations and there can be no assurance that our portfolio would perform in line with the estimated values.

As of December 31, 2002, we had $60 million in borrowings outstanding under a revolving credit facility. The average cost of borrowing on the revolving credit facility for 2002, including the amortization of deferred financing fees and the impact of the swap agreement, was 7.4%. If the average cost of borrowing on the amount outstanding as of December 31, 2002 were to increase by a factor of 1.1, our annual income before tax would decrease by approximately $400,000.

As of December 31, 2002, CII had $14.0 million principal amount of senior debentures outstanding, which is net of $1.0 million in debentures purchased by Sierra and eliminated upon consolidation. The market value of the outstanding debentures was estimated to be approximately $13.1 million at December 31, 2002, based on the last trade in 2002 before the debentures were no longer listed by the New York Stock Exchange. If interest rates were to fluctuate by a factor of 1.1, we do not anticipate a material change in the fair value of the debentures based on the current market for them.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

INDEX TO FINANCIAL STATEMENTS

MANAGEMENT REPORT ON CONSOLIDATED FINANCIAL STATEMENTS

The management of Sierra Health Services, Inc. is responsible for the integrity and objectivity of the accompanying consolidated financial statements. The statements have been prepared in conformity with accounting principles generally accepted in the United States of America applied on a consistent basis and are not misstated due to fraud or material error. The statements include some amounts that are based upon the Company's best estimates and judgment.

The accounting systems and controls of the Company are designed to provide reasonable assurance that transactions are executed in accordance with management's authorization, that the financial records are reliable for preparing financial statements and maintaining accountability for assets, and that assets are safeguarded against losses from unauthorized use or disposition. Management believes that for the year ended December 31, 2002, such systems and controls were adequate to meet the objectives discussed herein.

The accompanying consolidated financial statements have been audited by independent certified public accountants, whose audits thereof were made in accordance with auditing standards generally accepted in the United States of

America and included a review of internal accounting controls to the extent necessary to design audit procedures aimed at gathering sufficient evidence to provide a reasonable basis for their opinion on the fairness of presentation of the consolidated financial statements taken as a whole.

The Audit Committee of the Board of Directors, comprised solely of directors from outside the Company, meets regularly with management and the independent auditors to review the work procedures of each. The independent auditors have free access to the Audit Committee, without management being present, to discuss the results of their opinions on the adequacy of the Company's accounting controls and the quality of the Company's financial reporting. The Board of Directors, upon the recommendation of the Audit Committee, appoints the independent auditors, subject to stockholder ratification.

Anthony M. Marlon, M.D.
Chairman and Chief Executive Officer

Paul H. Palmer
Senior Vice President, Finance
Chief Financial Officer and Treasurer

INDEPENDENT AUDITORS' REPORT

To the Board of Directors and Stockholders of
Sierra Health Services, Inc.:

We have audited the accompanying consolidated balance sheets of Sierra Health Services, Inc. and its subsidiaries (the "Company") as of December 31, 2002 and 2001, and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2002. Our audits also included the financial statement schedules listed in the Index at Item 15 (a)(2). These financial statements and financial statement schedules are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and financial statement schedules based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used

and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Sierra Health Services, Inc. and its subsidiaries as of December 31, 2002 and 2001, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2002, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedules, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly in all material respects the information set forth therein.

As described in Note 18 to the notes to the consolidated financial statements, the Company adopted Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets" as of January 1, 2002.

DELOITTE & TOUCHE LLP

Las Vegas, Nevada
January 29, 2003, (March 14, 2003 as to Notes 6 and 19.)

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
December 31, 2002 and 2001
(In thousands, except share data)

	2002	2001
ASSETS		
CURRENT ASSETS:		
Cash and Cash Equivalents	$ 45,778	$ 107,114
Investments	182,452	52,498
Accounts Receivable (Less Allowance for Doubtful Accounts: 2002 - $10,626; 2001 - $11,251)	11,232	15,334
Military Accounts Receivable (Less Allowance for Doubtful Accounts: 2002 - $0; 2001 - $0)	47,126	40,166
Current Portion of Deferred Tax Asset	50,402	82,277
Prepaid Expenses and Other Current Assets	18,380	26,028
Assets of Discontinued Operations	565,058	533,673
Total Current Assets	920,428	857,090
PROPERTY AND EQUIPMENT, NET	64,868	136,496
RESTRICTED CASH AND INVESTMENTS	17,557	9,721
GOODWILL (Less: Accumulated Amortization $6,972)	14,782	14,782
DEFERRED TAX ASSET (Less Current Portion)	14,947	14,549
OTHER ASSETS	33,384	32,208

TOTAL ASSETS	$ 1,065,966	$ 1,064,846
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES:		
Accrued Liabilities	$ 50,349	$ 40,691
Trade Accounts Payable	29,249	22,500
Accrued Payroll and Taxes	13,660	13,465
Medical Claims Payable	98,031	81,662
Unearned Premium Revenue	40,758	38,592
Military Health Care Payable	65,223	77,261
Current Portion of Long-term Debt	186	191
Liabilities of Discontinued Operations	500,720	516,742
Total Current Liabilities	798,176	791,104
LONG-TERM DEBT (Less Current Portion)	60,710	163,993
OTHER LIABILITIES	50,515	13,230
TOTAL LIABILITIES	909,401	968,327
COMMITMENTS AND CONTINGENCIES		
STOCKHOLDERS' EQUITY:		
Preferred Stock, $.01 Par Value, 1,000 Shares Authorized; None Issued or Outstanding		
Common Stock, $.005 Par Value, 60,000 Shares Authorized; Shares Issued: 2002 - 30,953; 2001 - 29,648	155	148
Treasury Stock: 2002 - 1,163; 2001 - 1,523 Common Stock Shares	(17,148)	(22,789)
Additional Paid-In Capital	196,711	181,076
Deferred Compensation	(473)	(1,058)
Accumulated Other Comprehensive Gain (Loss)	381	(5,636)
Accumulated Deficit	(23,061)	(55,222)
TOTAL STOCKHOLDERS' EQUITY	156,565	96,519
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 1,065,966	$ 1,064,846

See the accompanying notes to consolidated financial statements.

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
For the Years Ended December 31, 2002, 2001 and 2000
(In thousands, except per share data)

	2002	2001	2000
OPERATING REVENUES:			

Medical Premiums	$ 857,741	$ 718,994	$ 637,76
Military Contract Revenues	373,589	338,918	330,35
Professional Fees	30,923	28,985	33,10
Investment and Other Revenues	16,382	16,603	18,39
Total	1,278,635	1,103,500	1,019,61
OPERATING EXPENSES:			
Medical Expenses	712,290	608,757	576,73
Military Contract Expenses	360,375	331,621	323,26
General and Administrative Expenses	133,979	122,623	112,22
Asset Impairment, Restructuring, Reorganization and Other Costs	--	--	30,83
Total	1,206,644	1,063,001	1,043,05
OPERATING INCOME (LOSS) FROM CONTINUING OPERATIONS	71,991	40,499	(23,44
Interest Expense	(7,487)	(15,786)	(17,86
Other Income (Expense), Net	(108)	(2,071)	1,08
INCOME (LOSS) FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	64,396	22,642	(40,22
(PROVISION) BENEFIT FOR INCOME TAXES	(22,088)	(7,161)	9,20
INCOME (LOSS) FROM CONTINUING OPERATIONS	42,308	15,481	(31,01
LOSS FROM DISCONTINUED OPERATIONS (net of income tax benefit of $2,945, $5,403 and $65,020)	(5,860)	(11,995)	(168,89
NET INCOME (LOSS)	$ 36,448	$ 3,486	$ (199,91
EARNINGS PER COMMON SHARE:			
Income (Loss) From Continuing Operations	$ 1.47	$ 0.56	$ (1.1
Loss from Discontinued Operations	(0.20)	(0.43)	(6.2
Net Income (Loss)	$ 1.27	$ 0.13	$ (7.3
EARNINGS PER COMMON SHARE ASSUMING DILUTION:			
Income (Loss) From Continuing Operations	$ 1.36	$ 0.54	$ (1.1
Loss from Discontinued Operations	(0.19)	(0.42)	(6.2
Net Income (Loss)	$ 1.17	$ 0.12	$ (7.3

See the accompanying notes to consolidated financial statements.

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
For the Years Ended December 31, 2002, 2001 and 2000
(In thousands)

	Common Stock		In Treasury		Addition Paid-I
	Shares	Amount	Shares	Amount	Capita
BALANCE, JANUARY 1, 2000	28,400	$ 142	1,523	$(22,789)	$ 175,9
Common Stock Issued in Connection with Stock Plans	415	2	--	--	1,5
Comprehensive Income:					
Net Loss	--	--	--	--	
Other Comprehensive Loss:					
Unrealized Holding Gain on Available-for-Sale Investments ($17,065 pretax)	--	--	--	--	
Reclassification Adjustment for Gains Included in Net Income ($1,071 pretax)	--	--	--	--	
Total Comprehensive Income (Loss)	--	--	--	--	
BALANCE, DECEMBER 31, 2000	28,815	144	1,523	(22,789)	177,4
Common Stock Issued in Connection with Stock Plans	589	3	--	--	2,0
Income Tax Benefit Realized Upon Exercise of Stock Options	--	--	--	--	
Issuance of Restricted Stock	244	1	--	--	1,3
Amortization of Deferred Compensation	--	--	--	--	
Comprehensive Income:					
Net Income	--	--	--	--	
Other Comprehensive Income:					
Unrealized Holding Gain on Available-for-Sale Investments ($374 pretax)	--	--	--	--	
Reclassification Adjustment for Gains Included in Net Income ($326 pretax)	--	--	--	--	
Total Comprehensive Income	--	--	--	--	
BALANCE, DECEMBER 31, 2001	29,648	148	1,523	(22,789)	181,0
Common Stock Issued in Connection with Stock Plans	1,305	7	(360)	5,641	8,7
Income Tax Benefit Realized Upon Exercise of Stock Options	--	--	--	--	6,8
Amortization of Deferred Compensation	--	--	--	--	
Comprehensive Income:					
Net Income	--	--	--	--	
Other Comprehensive Income:					
Unrealized Holding Gain on Available-for-Sale Investments ($10,671 pretax)	--	--	--	--	
Reclassification Adjustment for Losses Included in Net Income ($217 pretax)	--	--	--	--	
Minimum Pension Liability Adjustment ($1,630 pretax)	--	--	--	--	
Total Comprehensive Income	--	--	--	--	
BALANCE, DECEMBER 31, 2002	30,953	$ 155	1,163	$(17,148)	$ 196,7

See the accompanying notes to consolidated financial statements.

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 2002, 2001 and 2000
(In thousands)

	Years Ended December 31,		
	2002	2001	200
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net Income (Loss)	$ 36,448	$ 3,486	$ (199,
Adjustments to Reconcile Net Income (Loss) to Net Cash Provided by Operating Activities:			
Loss from Discontinued Operations	5,860	11,995	168,
Depreciation and Amortization	18,245	24,184	24,
Deferred Compensation Expense	585	342	
Provision for Doubtful Accounts	2,835	1,251	1,
Provision for Asset Impairment	--	--	36,
Loss (Gain) on Property and Equipment Dispositions	17	2,311	(1,
Change in Assets and Liabilities:			
Other Assets	(16)	2,839	(7,
Deferred Tax Asset	37,931	2,107	(51,
Other Current Liabilities	14,660	3,853	(19,
Accounts Receivable	1,267	(2,921)	3,
Other Current Assets	6,454	(2,153)	2,
Military Accounts Receivable	(6,960)	32,436	(11,
Military Health Care Payable	(12,038)	(7,598)	34,
Medical Claims Payable	16,369	7,258	9,
Other Liabilities	14,980	18,774	8,
Net Cash Provided by Operating Activities of Continuing Operations	136,637	98,164	(2,
CASH FLOWS FROM INVESTING ACTIVITIES:			
Capital Expenditures	(12,392)	(7,136)	(14,
Property and Equipment Dispositions	680	7,265	10,
Purchase of Available-for-Sale Investments	(847,437)	(130,625)	(37,
Proceeds from Sales/Maturities of Available-for-Sale Investments	712,483	107,540	57,
Net Cash (Used for) Provided by Investing Activities of Continuing Operations	(146,666)	(22,956)	16,
CASH FLOWS FROM FINANCING ACTIVITIES:			
Proceeds from Long-term Borrowing	--	--	91,
Proceeds on Sale-Leaseback Deposit	16,862	--	
Payments on Debt and Capital Leases	(30,399)	(53,187)	(39,
Exercise of Stock in Connection with Stock Plans	10,159	2,090	1,

Net Cash (Used for) Provided by Financing Activities of Continuing Operations	(3,378)	(51,097)	53,
NET CASH (USED FOR) PROVIDED BY DISCONTINUED OPERATIONS	(47,929)	(45,954)	24,
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(61,336)	(21,843)	91,
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	107,114	128,957	37,
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 45,778	$ 107,114	$ 128,

See the accompanying notes to consolidated financial statements.

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1. BUSINESS

Business

. The consolidated financial statements include the accounts of Sierra Health Services, Inc. and its subsidiaries (collectively referred to as "Sierra" or the "Company"). Sierra is a managed health care organization that provides and administers the delivery of comprehensive health care programs with an emphasis on quality care and cost management. Sierra's broad range of managed health care services is provided through its health maintenance organization ("HMO"), managed indemnity plans, military health services programs, third-party administrative services programs for employer-funded health benefit plans and medical management programs. Ancillary products and services that complement the Company's managed health care product lines are also offered.

The Company's continuing operations currently operate in two reportable segments: managed care and corporate operations and military health services operations. The Company's prior third reportable segment, workers' compensation operations, has been classified as a discontinued operation.

Discontinued Operations.

In accordance with Statement of Financial Accounting Standards No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets" ("SFAS No. 144"), during the fourth quarter of 2002, the Company reclassified it's workers' compensation insurance operations as discontinued operations. Sierra is seeking strategic alternatives for the workers' compensation insurance subsidiaries and has retained Banc of America Securities to explore strategic alternatives for the operations.

During the third quarter of 2001, the Company announced its plan to exit the Texas HMO health care market and received formal approval from the Texas Department of Insurance to withdraw its HMO operations in mid-October. The Company ceased providing HMO health care coverage in Texas on April 17, 2002.

The individual line items on the consolidated balance sheets have been presented net of the discontinued operations with the total assets and liabilities of the discontinued operations presented on one line within current assets and current liabilities, respectively. The results of operations from the discontinued operations have been reported net of tax as a separate component of income on the consolidated statements of operations. The cash flows from the discontinued operations have been reported as a separate component on the consolidated statements of cash flows. See Notes 8 and 9 for disclosure on and a description of the discontinued operations.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation

. All significant intercompany transactions and balances have been eliminated in consolidation. Sierra's consolidated subsidiaries include: Health Plan of Nevada, Inc. ("HPN") and Texas Health Choice, L.C. ("TXHC"), which are licensed HMOs; Sierra Health and Life Insurance Company, Inc. ("SHL"), a health and life insurance company; Southwest Medical Associates, Inc. ("SMA"), a multi-specialty medical provider group; Sierra Military Health Services, Inc., and its subsidiary, ("SMHS"), a company that provides and administers managed care services to certain TRICARE eligible beneficiaries; CII Financial, Inc. ("CII"), a holding company primarily engaged in writing workers' compensation insurance through its wholly-owned subsidiaries; administrative services companies; a home health care agency; a hospice; a home medical products subsidiary; and a company that provides and manages mental health and substance abuse services. CII and TXHC have been reported as part of the discontinued operations.

Medical Premiums

. Membership contracts are generally established on an annual basis subject to cancellation by the employer group or Sierra generally upon 60 days written notice. Premiums, including premiums from both commercial and governmental programs, are due monthly and are recognized as revenue during the period in which members are entitled to receive services and are net of estimated retroactive adjustments of members and groups. Non-Medicare member enrollment is represented principally by employer groups. HPN offers a prepaid health care program to Medicare recipients. Revenues associated with Medicare recipients were approximately $340.1 million, $304.7 million and $267.9 million in 2002, 2001 and 2000, respectively. Premiums collected in advance are recorded as unearned premium revenue and can include payments under prepaid Medicare contracts with the Centers for Medicare and Medicaid Services ("CMS") and prepaid HPN commercial and SHL preferred provider organization premiums.

Military Contract Revenues.

Revenue under the Department of Defense TRICARE contract is recorded based on the contract price as agreed to by the federal government. The contract also contains provisions which adjust the contract price based on actual experience and for government-directed change orders. The estimated effects of these adjustments are recognized on a monthly basis once the amount is reasonably known. In addition, the Company records revenue based on estimates of the earned portion of any contract change orders not originally specified in the contract. Enrollment fees collected in advance of the service period are recorded as unearned premium revenue.

Professional Fees.

Revenue for professional medical services is recorded on the accrual basis in the period in which the services are provided. Such revenue is recorded at established rates, net of provisions for estimated contractual allowances.

Investment and Other Revenues.

Investment income is recognized in the period earned, realized gains and losses are recognized as incurred and are calculated using the specific identification method. Other revenues include administrative services fees and certain

ancillary product revenues. In prior years these revenues had been reported as specialty product revenues. Such revenues are recognized in the period in which the service is performed or the period that coverage for services is provided.

Medical Expenses.

Health care expenses are recorded in the period when services are provided to enrolled members, including estimates for provider costs which have been incurred as of the balance sheet date but not yet reported to the Company. The Company uses a variety of standard actuarial projection methods to make these estimates and must use judgment in selecting development factors and assumed trends. In making projections, the Company considers medical cost utilization and trends, changes in internal processes, the average interval between the date services are rendered and the date claims are received and/or paid, denied claims activity, disputed claims activity, seasonality patterns and changes in membership. Assumptions could be affected by the timing of the receipt of claims, the timing of processing claims and unanticipated changes, such as adverse legal outcomes, legislative or regulatory changes, new interpretations of existing laws or regulations or disputed contract provisions that result in the Company's having to provide new or extended benefits and changes in the Company's health care delivery system or costs. The Company believes that the recorded liability for medical claims payable, at December 31, 2002, is reasonable and adequate to cover future health care claim payments. Any subsequent changes in an estimate for a prior year would be reflected in the current year's operating results.

The Company contracts with hospitals, physicians and other independently contracted providers of health care under capitated or discounted fee-for-service arrangements including hospital per diems to provide medical care services to enrollees. Capitated providers are at risk for a portion of the cost of medical care services provided to the Company's enrollees in the relevant geographic areas; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

Military Contract Expenses.

This expense consists primarily of costs to provide managed health care services to eligible beneficiaries in accordance with the Company's TRICARE contract. Under the contract, SMHS provides health care services to approximately 678,000 dependents of active duty military personnel, military retirees under the age of 65 and dependents of military retirees through a network of approximately 55,000 health care providers and certain other subcontractor partnerships. Health care costs are recorded in the period when services are provided to eligible beneficiaries including estimates for provider costs which have been incurred as of the balance sheet date but not reported to the Company. Also included in military contract expenses are costs incurred to perform specific administrative services, such as health care appointment scheduling, enrollment, network management and health care advice line services and other administrative functions of the military health care subsidiary. These administrative services are performed for active duty personnel and dependants as well as retired military families.

Cash and Cash Equivalents

. The Company considers cash and cash equivalents as all highly liquid instruments with a maturity of three months or less at time of purchase. The carrying amount of cash and cash equivalents approximates fair value because of the short maturity of these instruments.

Investments

. Investments consist principally of U.S. Government and its agencies' securities and municipal bonds, as well as corporate and mortgage-backed securities. All non-restricted investments that are designated as available-for-sale are classified as current assets. These investments are available for use in the current operations regardless of contractual maturity dates. Non-restricted investments designated as held-to-maturity are classified as current assets if expected

maturity is within one year of the balance sheet date. Otherwise, they are classified as long-term investments. All of the Company's held-to-maturity investments are held by the discontinued operations. Realized gains and losses are calculated using the specific identification method and are included in investment and other revenues. Unrealized holding gains and losses on available-for-sale securities are included as a separate component of stockholders' equity, net of income tax effects, until realized.

Restricted Cash and Investments

. Certain subsidiaries are required by state regulatory agencies to maintain deposits and must also meet net worth and reserve requirements. The Company believes its subsidiaries are in compliance with the applicable minimum regulatory and capital requirements.

Military Accounts Receivable.

Amounts receivable under government contracts are comprised primarily of estimates of adjustments under the contract based on actual experience and estimates of the earned portion of any change orders not originally specified in the contract.

During 2001, SMHS adopted SFAS No. 140, "Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities", which provides accounting and reporting standards for securitizations and other transfers of financial assets and extinguishments of liabilities. On November 16, 2001, SMHS entered into a securitization arrangement with General Electric Capital Corporation. The arrangement provides for the assignment of SMHS' Federal Government accounts receivable to SMHS Funding. SMHS Funding is a special purpose limited liability company owned by SMHS and was formed for the purpose of purchasing all receivables of SMHS. This entity is fully consolidated into SMHS. SMHS Funding, LLC may assign an undivided interest in certain of the receivables to a subsidiary of General Electric Capital Corporation in the event that additional financing by SMHS is warranted.

As of and for the year ended December 31, 2002, SMHS has not utilized the facility and is currently incurring an unused facility fee of 0.5% per annum calculated daily and payable monthly in arrears on the unused portion of the maximum purchase limit of $32 million.

Reinsurance Recoverable.

In the normal course of business, the Company seeks to reduce the effects of catastrophic and other events that may cause unfavorable underwriting results by reinsuring certain levels of risk with other reinsurers. Reinsurance receivable for ceded paid claims is recorded in accordance with the terms of the agreements and reinsurance recoverable for unpaid losses and loss adjustment expense and medical claims payable is estimated in a manner consistent with the claim liability associated with the reinsurance policy. Reinsurance receivables, including amounts related to paid and unpaid losses, are reported as assets rather than a reduction of the related liabilities.

The Company is covered under medical reinsurance agreements that provide coverage for 50% - 90% of hospital and other costs in excess of $300,000 per case, up to a maximum of $2.0 million per member per lifetime for both the managed indemnity and HMO subsidiaries.

Certain of the Company's HMO members are covered by an excess catastrophe reinsurance contract and SHL maintains reinsurance on certain of its insurance products. Reinsurance premiums of $2.3 million, $1.7 million and $2.4 million, net of reinsurance recoveries of $1.3 million, $1.8 million and $1.9 million, are included in medical expenses for 2002, 2001 and 2000, respectively.

See Note 9 for a discussion of the workers' compensation insurance operations' reinsurance.

Property and Equipment.

Property and equipment are stated at cost less accumulated depreciation. Maintenance and repairs that do not significantly improve or extend the life of the respective assets are charged to operations. Depreciation is computed using the straight-line method over the estimated service lives of the assets or terms of leases if shorter. Estimated useful lives are as follows:

Buildings and Improvements	10 - 30 years
Leasehold Improvements	3 - 10 years
Furniture, Fixtures and Equipment	3 - 5 years
Data Processing Hardware and Software	3 - 10 years

Goodwill.

Goodwill has been recorded as a result of various business acquisitions by the Company. On January 1, 2002, the Company adopted Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets" ("SFAS No. 142"). SFAS No. 142 required, among other things, the discontinuance of goodwill amortization and the Company to complete a transitional goodwill impairment test six months from the date of adoption and at least annually thereafter. The Company has completed its transitional goodwill test and determined that the recorded goodwill was not impaired under the guidelines of the pronouncement. This test involved the use of estimates related to the fair value of the business with which the goodwill is allocated. The goodwill balance at December 31, 2002, was $14.8 million, all of which is part of the managed care and corporate operations segment. Amortization expense, from continuing operations, associated with goodwill was $805,000, and $1.1 million for the years ended December 31, 2001 and 2000, respectively. See Note 18 for a pro forma table presenting the results of operations as though SFAS No. 142 occurred as of January 1, 2000.

In connection with the restructuring plans adopted and announced by the Company in the second quarter of 2000, the Company re-evaluated the recoverability of certain long-lived assets, primarily those associated with the Texas HMO health care operations, in accordance with Statement of Financial Accounting Standards No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed Of" ("SFAS No. 121") and Accounting Principles Board Opinion No. 17, "Intangible Assets" ("APB No. 17"), and determined that the carrying value of certain goodwill was impaired. In assessing the asset impairment of the long- lived assets, the Company first allocated a portion of related goodwill to the fixed assets to be disposed of, in accordance with SFAS No. 121. The remainder of the related goodwill was then assessed for recoverability in accordance with APB No. 17 based on projected discounted cash flows and an impairment of $141.5 million was recorded. Of the total impairment, $126.4 million was related to and has been recorded as part of discontinued operations. See Notes 8 and 16 for a description of the primary facts and circumstances related to the impairment.

Treasury Stock.

Shares purchased and placed in treasury are valued at cost. Subsequent sales of treasury stock at amounts in excess of their cost are credited to additional paid-in capital. Sale of treasury stock at amounts below their cost are charged to additional paid-in capital to the extent it includes gains from previous sales and the remainder to retained earnings (accumulated deficit). Sales of treasury shares in 2002, at amounts below their cost of $4.3 million, were charged to accumulated deficit as the Company did not previously have gains in additional paid-in capital. All sales of treasury shares in 2002 were in connection with the exercise of stock options.

Stock Option Plans.

The Company has several plans which are described more fully in Note 13. The Company's stock option plans are accounted for using the intrinsic value method. Accordingly, no compensation cost has been recognized for its employee stock option plans. Had compensation cost for the Company's stock-based compensation plans been determined based on the fair value at the grant dates for awards under those plans, the Company's net income and earnings per share for the years ended December 31, would have been reduced to the pro forma amounts indicated below:

	Years ended December 31		
	2002	2001	2000
	(In thousands, except per share data)		
Net income (loss), as reported	$ 36,448	$ 3,486	$(199,915)
Less: total stock-based employee compensation expense determined under fair value based methods for all awards, net of tax	(4,598)	(3,506)	(3,378)
Pro forma net income (loss)	$ 31,850	$ (20)	$(203,293)
Net income (loss) per share, as reported	$ 1.27	$ 0.13	$ (7.37)
Pro forma net income (loss)	1.11	--	(7.49)
Net income (loss) per share assuming dilution, as reported	$ 1.17	$ 0.12	$ (7.37)
Pro forma net income (loss)	1.02	--	(7.49)

Due to the fact that the Company's stock option programs vest over many years and additional awards are made each year, the above pro forma numbers are not indicative of the financial impact had the disclosure provisions of Statement of Financial Accounting Standards No. 123, "Accounting for Stock-Based Compensation" been applicable to all the years of previous option grants. The above numbers do not include the effect of options granted prior to 1995. See Note 13 for a discussion of the assumptions used in the option pricing model and estimated fair value of employee stock options.

In December 2002, the FASB issued Statement of Financial Accounting Standards No. 148, "Accounting for Stock-Based Compensation - Transition and Disclosure" ("SFAS No. 148"). SFAS No. 148 is an amendment of Statement of Financial Accounting Standards No. 123. SFAS No. 148 provides alternative methods of transition for a voluntary change to the fair value based method of accounting for stock-based employee compensation. In addition, SFAS No. 148 requires prominent disclosures in interim as well as annual financial statements about the method of accounting for stock-based employee compensation and the effect of the method used on reported net income. The disclosure requirements of SFAS No. 148 are effective for fiscal years ended after December 15, 2002. The Company has not yet determined if it will implement the voluntary change to the fair value based method of accounting as allowed under SFAS No. 148 for 2003.

Premium Deficiency Reserves.

Premium deficiency expenses are recognized when it is probable that the future costs associated with a group of existing contracts will exceed the anticipated future premiums on those contracts. The Company calculates expected premium deficiency expense based on budgeted revenues and expenses. Premium deficiency reserves are evaluated quarterly for adequacy.

Income Taxes.

The Company accounts for income taxes using the liability method. Deferred income tax assets and liabilities result from temporary differences between the tax basis of assets and liabilities and the reported amounts in the consolidated financial statements that will result in taxable or deductible amounts in future years. The Company's temporary differences arise principally from certain net operating losses, accrued expenses, reserves, depreciation and impairment charges.

Concentration of Credit Risk.

The Company's financial instruments that are exposed to credit risk consist primarily of cash equivalents, investments and accounts receivable. The Company maintains cash and cash equivalents and investments with various financial institutions. These financial institutions are located in many different regions and company policy is designed to limit exposure with any one institution.

Credit risk with respect to accounts receivable is generally diversified due to the large number of entities comprising the Company's customer base and their dispersion across many different industries. These customers are primarily located in the states in which the Company operates and are principally in California and Nevada. However, the Company is licensed and does business in several other states. As of December 31, 2002, the Company had receivables outstanding from the federal government related to its TRICARE contract in the amount of $47.1 million. The Company also has receivables from its reinsurers. Reinsurance contracts do not relieve the Company from its obligations to enrollees or policyholders. Failure of reinsurers to honor their obligations could result in losses to the Company. The Company evaluates the financial condition of its reinsurers to minimize its exposure to significant losses from reinsurer insolvencies. All reinsurers with whom the Company has reinsurance contracts are rated AA- and A+ or better by Fitch Ratings and the A.M. Best Company, respectively.

Derivatives

. The Company's only derivative instrument is an interest rate swap agreement used to minimize interest rate risk. As of January 1, 2001, the Company implemented Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"). The implementation did not result in an adjustment to our consolidated financial position or results of operations. Sierra accounts for derivative instruments on the balance sheet at fair value with changes in fair values reported as part of net income.

Recently Issued Accounting Standards.

In November 2002, the FASB issued Interpretation No. 45, "Guarantor's Accounting and Disclosure Requirements for Guarantees" ("FIN 45"). FIN 45 requires a guarantor to recognize, at the inception of a guarantee, a liability for the fair value of the obligation it has undertaken in issuing the guarantee. The Company will apply FIN 45 to guarantees, if any, issued after December 31, 2002. The Company does not expect the adoption of FIN 45 to have a material effect on our consolidated financial position or results of operations.

In January 2003, the FASB issued Interpretation No. 46, "Consolidation of Variable Interest Entities" ("FIN 46"). FIN 46 requires an investor with a majority of the variable interests in a variable interest entity to consolidate the entity and also requires majority and significant variable interest investors to provide certain disclosures. A variable interest entity is an entity in which the equity investors do not have a controlling interest or the equity investment at risk is insufficient to finance the entity's activities without receiving additional subordinated financial support from the other parties. The Company does not expect the adoption of FIN 46 to have a material effect on our consolidated financial position or results of operations.

In April 2002, the FASB issued Statement of Financial Accounting Standards No. 145, "Recission of FASB Statements No. 4, 44, and 64, Amendment of FASB Statement No. 13, and Technical Corrections" ("SFAS No. 145"). SFAS No. 145 requires that gains and losses from extinguishment of debt be classified as extraordinary items only if they meet the criteria in Accounting Principles Board Opinion No. 30 ("Opinion No. 30"). Applying the provisions of Opinion No. 30 will distinguish transactions that are part of an entity's recurring operations from those that are unusual and infrequent that meet the criteria for classification as an extraordinary item. SFAS No. 145 is effective for the Company beginning January 1, 2003. The Company does not expect the adoption of SFAS No. 145 to have a material effect on our consolidated financial position or results of operations.

In June 2002, the FASB issued Statement of Financial Accounting Standards No. 146, "Accounting for Costs Associated with Exit or Disposal Activities" ("SFAS No. 146"). SFAS No. 146 addresses financial accounting and reporting for costs associated with exit or disposal activities and nullifies Emerging Issues Task Force Issue No. 94-3, "Liability Recognition for Certain Employee Termination Benefits and Other Costs to Exit an Activity (including Certain Costs Incurred in a Restructuring)". SFAS No. 146 requires that a liability for a cost associated with an exit or disposal activity be recognized when the liability is incurred. A fundamental conclusion reached by the FASB in this statement is that an entity's commitment to a plan, by itself, does not create a present obligation to others that meets the definition of a liability. SFAS No. 146 also establishes that fair value is the objective for initial measurement of the liability. The provisions of this statement are effective for exit or disposal activities that are initiated after December 31, 2002, with early adoption encouraged. The Company did not elect to early adopt SFAS No. 146 nor does it expect the adoption to have a material effect on its consolidated financial position or results of operations.

Use of Estimates and Assumptions in the Preparation of Financial Statements.

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Management must exercise its judgment taking into consideration the facts and circumstances in selecting assumptions and other factors in calculating its estimates. On an on-going basis, management re-evaluates its assumptions and the methods of calculating its estimates. Estimates and assumptions include, but are not limited to, medical and workers' compensation expenses and reserves, military revenue and expenses, reinsurance recoverables, legal reserves, fair values of investments, amounts receivable or payable under government contracts, deferred income taxes, remaining reserves for restructuring and other charges and the net realizable values for assets where impairment charges have been recorded. Actual results may materially differ from estimates.

Reclassifications.

Certain amounts in the Consolidated Financial Statements as of and for the years ended December 31, 2001 and 2000 have been reclassified to conform with the current year presentation. The reclassifications have no effect on net income or stockholders' equity as previously reported.

3. EARNINGS PER SHARE

The following table provides a reconciliation of basic and diluted earnings per share ("EPS"):

	Years ended December 31,		
	2002	2001	2000
(In thousands, except per share data)			

Income (loss) from continuing operations.....	$ 42,308	$ 15,481	$ (31,019)
Loss from discontinued operations.....	(5,860)	(11,995)	(168,896)
Net income (loss).....	$ 36,448	$ 3,486	$ (199,915)
Earnings per common share:			
Income (loss) from continuing operations.....	$ 1.47	$ 0.56	$ (1.15)
Loss from discontinued operations.....	(0.20)	(0.43)	(6.22)
Net income (loss).....	$ 1.27	$ 0.13	$ (7.37)
Earnings per common share assuming dilution:			
Income (loss) from continuing operations.....	$ 1.36	$ 0.54	$ (1.15)
Loss from discontinued operations.....	(0.19)	(0.42)	(6.22)
Net income (loss).....	$ 1.17	$ 0.12	$ (7.37)
Weighted average common shares outstanding...	28,756	27,685	27,142
Dilutive options outstanding.....	2,141	787	--
Restricted Shares outstanding.....	244	37	--
Weighted average common shares outstanding assuming dilution.....	31,141	28,509	27,142

Stock options to purchase 325,000 shares in 2002 and 1,591,000 shares in 2001 were not dilutive and, therefore, were not included in the computations of diluted earnings per share. Stock options to purchase 4,250,000 shares of common stock were outstanding at December 31, 2000, but were not included in the computation of diluted earnings per share because the Company had a net operating loss for the year and their inclusion would have been anti-dilutive.

CII issued convertible subordinated debentures (the "Debentures") due September 15, 2001. Each $1,000 in principal was convertible into 25.382 shares of the Company's common stock at a conversion price of $39.398 per share. The Debentures were paid off in September 2001 and they have not been included in the computation of EPS during the years presented because their effect would be anti-dilutive.

4

. **PROPERTY AND EQUIPMENT**

Property and equipment at December 31, consists of the following:

	2002	**2001**
	(In thousands)	
Land.....	$ 2,984	$ 11,147
Buildings and Improvements.....	22,415	99,472
Furniture, Fixtures and Equipment.....	39,286	36,945
Data Processing Equipment and Software.....	98,216	91,060
Software in Development and Construction in Progress.....	697	2,331
Less: Accumulated Depreciation	(98,730)	(104,459)
Property and Equipment, Net.....	$ 64,868	$ 136,496

The following is an analysis of property and equipment under capital lease by classification as of December 31:

	2002	2001
	(In thousands)	
Buildings and Improvements	$ 245	$ 245
Data Processing Equipment and Software	333	333
Less: Accumulated Depreciation	(413)	(316)
Property and Equipment, Net	$ 165	$ 262

The Company capitalizes interest expense as part of the cost of construction of facilities and the implementation of computer systems. Interest expense capitalized in 2002, 2001 and 2000 was $50,000, $29,000, and $67,000, respectively. Depreciation expense, from continuing operations, in 2002, 2001 and 2000 was $18.2 million, $23.4 million and $23.0 million, respectively.

Sale-Leaseback.

On December 28, 2000, the Company sold the majority of its Las Vegas, Nevada administrative and medical clinic real estate holdings in a sale-leaseback transaction. As part of the transaction, the Company financed a portion of the sales price with mortgage notes receivable of $22.2 million and provided deposits of $4.3 million. The mortgages and deposits constituted continuing involvement as defined in Statement of Financial Accounting Standards No. 98, "Accounting for Leases" ("SFAS No. 98"), and as such the transaction did not qualify as a sale. In accordance with SFAS No. 98, the Company recorded the transaction as a financing obligation of $113.7 million, offset by the mortgage notes receivable of $22.2 million. The net book value of the assets included in the transaction was $86.9 million at December 31, 2000. For the assets that did not qualify for sale treatment, depreciation expense and interest expense were recognized on the net book value of the assets and net financing obligation outstanding, respectively.

As of September 30, 2002, the Company had received the deposits back and full payment of the outstanding mortgage obligations. The payments cured the continuing involvement criteria of SFAS No. 98 and the transaction then qualified as a sale. To record the sale, the Company retired the assets and their associated accumulated depreciation and financing obligation and recorded a deferred gain to be recognized over the remaining 13 year term of the lease. The impact of the sale of the buildings recorded during 2002 was a net reduction of $68.8 million in property and equipment, a net reduction of $89.8 million in the associated financing obligation and a deferred gain of $21.0 million. The total deferred gain recorded on the transaction in 2001 and 2002 was $25.7 million; $1.9 million will be recognized annually over the remaining term of the lease.

5.

CASH AND INVESTMENTS

Investments that the Company has the intention and ability to hold to maturity are stated at amortized cost and categorized as held-to- maturity. All of the held-to-maturity investments are part of the discontinued workers'

compensation operations. The remaining investments have been categorized as available-for-sale and are stated at their fair value. Fair value is estimated primarily from published market values as of the balance sheet date. Gross realized gains on investments, from continuing operations, for 2002, 2001 and 2000 were $82,000, $27,000 and $44,000, respectively. Gross realized losses on investments, from continuing operations, for 2002, 2001 and 2000 were $84,000, $92,000 and $497,000, respectively.

The following table summarizes the Company's current and restricted investments, from continuing operations, as of December 31, 2002:

	Amortized Cost	Unrealized Gains	Unrealiz Losses
			(In thousands
Available-for-Sale Investments:			
Classified as Current:			
U.S. Government and its Agencies	$ 35,338	$ 747	$ 1
Municipal Obligations	87,701	21	8
Corporate Bonds	54,845	4	-
Other Debt Securities	1,161	4	-
Total Debt Securities	179,045	776	10
Preferred Stock	2,754	20	4
Total Current	181,799	796	14
Classified as Restricted:			
U.S. Government and its Agencies	8,785	208	-
Municipal Obligations	1,397	43	1
Other Debt Securities	7,134	--	-
Total Restricted	17,316	251	1
Total Available-for-Sale	$ 199,115	$ 1,047	$ 15

The following table summarizes the Company's current and restricted investments, from continuing operations, as of December 31, 2001:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealiz Losses
			(In thousands
Available-for-Sale Investments:			
Classified as Current:			
U.S. Government and its Agencies	$ 36,093	$ --	$ 1,27
Municipal Obligations	14,188	--	34
Other Debt Securities	851	--	-
Total Debt Securities	51,132	--	1,61
Preferred Stock	3,013	--	2
Total Current	54,145	--	1,64

Classified as Restricted:			
U.S. Government and its Agencies	6,532	90	31
Municipal Obligations	1,348	39	-
Other	2,029	--	-
Total Restricted	9,909	129	31
Total Available-for-Sale	$ 64,054	$ 129	$ 1,96

The contractual maturities of available-for-sale debt securities at December 31, 2002 are shown below:

	Amortized Cost	Fair Value
	(In thousands)	
Due in one year of less	$ 88,842	$ 88,877
Due after one year through five years	55,212	55,719
Due after five years through ten years	16,736	16,688
Due after ten years through fifteen years	6,700	6,702
Due after fifteen years	28,871	29,290
Total	$ 196,361	$ 197,276

Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations.

Of the cash and cash equivalents and current investments that total $228.2 million in the accompanying Consolidated Balance Sheet at December 31, 2002, $168.6 million is limited for use only by the Company's regulated subsidiaries. Such amounts are available for transfer to Sierra from the regulated subsidiaries only to the extent that they can be remitted in accordance with terms of existing management agreements and by dividends, which customarily must be approved by regulating state insurance departments. The remainder is available to Sierra on an unrestricted basis.

6. DEBT

Debt at December 31, consists of the following:

	2002	2001
	(In thousands)	
Revolving Credit Facility	$ 60,000	$ 89,000
Net Financing Obligations	--	73,948
Other	896	1,236
Total	60,896	164,184
Less Current Portion	(186)	(191)
Long-term Debt	$ 60,710	$ 163,993

Revolving Credit Facility.

On October 31, 1998, the Company replaced its prior line of credit with a $200 million credit facility. As a result of the asset impairment and other changes in estimate charges, the Company was not in compliance with its financial covenants at June 30, 2000. On December 15, 2000, the Company entered into an amended and restated credit agreement, which was set to mature on September 30, 2003. The Company believes it complied with all covenants of the amended agreement. The amended and restated agreement was subsequently amended in April 2001 to allow for the completion of the CII debenture exchange offer and in October 2001 to provide a limited waiver for covenants affected by exiting the Texas HMO health care market. The amended and restated agreement was further amended in July and December 2002. The 2002 amendments allowed for CII to be classified as a discontinued operation and for a potential sale of CII and provided a limited waiver of covenants impacted by those actions. In addition, the 2002 amendments permitted the Company to purchase CII Debentures and Sierra common stock under certain circumstances. The amended and restated credit facility was terminated on March 3, 2003, and replaced by a new $65 million revolving credit facility. See Note 19 for a description of the new $65 million revolving credit facility.

The maximum availability under the amended and restated credit agreement was reduced to $95 million from $117 million at the end of 2001 due to required reductions in the agreement. At December 31, 2002, the Company had $35 million available under the agreement.

Subject to normal qualifications and exceptions, Sierra has covenants that, among other things, restrict its ability to dispose of assets, incur indebtedness, pay dividends, make investments, loans or advances, make acquisitions, engage in mergers or consolidations, or make capital expenditures and which otherwise restrict certain corporate activities. The terms of the amended and restated credit agreement contain certain covenants including a minimum fixed charge coverage ratio, a minimum interest coverage ratio, a maximum leverage ratio, maximum loss ratios and maximum capital expenditure amounts. The Company believes it is in compliance with all covenants at December 31, 2002.

The Company is not allowed to pay or declare any cash dividends on Sierra common stock under the terms of the amended and restated credit agreement. The Company has not paid or declared any cash dividends since inception. The Company anticipates that future earnings will be retained for our current operations; therefore, it does not plan to pay or declare any dividends on Sierra common stock in the foreseeable future.

Interest under the amended and restated credit agreement was variable and based on the Bank of America "prime rate" adjusted for a margin. The rate was 3.875% at December 31, 2002, which is a combination of the prime rate of 4.25% less a credit of .375%. Of the outstanding balance, $25 million is covered by an interest-rate swap agreement. To mitigate the risk of interest rate fluctuation on the credit facility, the Company entered into a five-year $50 million interest-rate swap agreement during the fourth quarter of 1998. The intent of the agreement was to keep the Company's interest rate on $50 million of the borrowing relatively fixed. In the fourth quarter of 2000, $25 million of the swap agreement was terminated. The interest rate swap is a derivative as described in SFAS No. 133 and the Company recorded a liability for the interest-rate swap agreement at its fair value of $645,000 as of December 31, 2002, compared to an indicated fair value of $685,000 at December 31, 2001. Previously, the fair value of the asset or liability related to the swap was immaterial. The fair value is the cost that the Company would need to pay to terminate the swap agreement as of December 31, 2002.

The average cost of borrowing on the amended and restated credit facility for 2002, including the amortization of deferred financing fees and the impact of the swap agreement, was 7.4%.

Net Financing Obligations

represent amounts recorded as a financing obligation as part of the sale-leaseback transaction described in Note 4. Amounts were recorded as a financing obligation as required by SFAS No. 98 using the interest method with effective interest rates of 8.16% to 8.53%. In conjunction with the transaction qualifying as a sale, as described in Note 4, the

Company no longer reflects a net financing obligation.

Other.

The Company has obligations under capital leases with interest rates from 8.0% to 12.2%. In addition, the Company has term loans with the City of Baltimore and the State of Maryland.

Scheduled maturities of the Company's notes payable, net financing obligations and future minimum payments under capital leases, together with the present value of the net minimum lease payments at December 31, 2002, are as follows:

	Notes Payable	Obligations Under Capital Leases
	(In thousands)	
Years ending December 31,		
2003	$ 93	$ 121
2004	31	83
2005	32	31
2006	60,033	31
2007	34	31
Thereafter	362	153
Total	$ 60,585	450
Less: Amounts Representing Interest		(139)
Present Value of Minimum Lease Payments		$ 311

The fair value of long-term debt, including the current portion, is estimated to be approximately $60.9 million based on the borrowing rates currently available to the Company.

7.

INCOME TAXES

A summary of the provision for income taxes for continuing operations for the years ended December 31, is as follows:

	2002	2001	2000
		(In thousands)	
Provision (Benefit) for Income Taxes:			
Current	$ (11,498)	$ (2,763)	$ (1,65
Deferred	33,586	9,924	(7,54
Total	$ 22,088	$ 7,161	$ (9,20

The following reconciles the difference between the reported and statutory provision (benefit) for income taxes, from continuing operations, for the years ended December 31:

	2002	2001	2000
Statutory Rate	35 %	35 %	(3
State Income Taxes	--	(1)	
Tax Preferred Investments	(1)	(1)	(
Change in Valuation Allowance	(3)	(2)	(
Intangible Amortization	--	1	1
Compensation and Benefit Plans	3	1	-
Other	--	(1)	
Provision (Benefit) for Income Taxes	34 %	32 %	(2

The tax effects of significant items comprising the Company's total net deferred tax assets, including discontinued operations, are as follows at December 31:

	2002	2001
	(In thousands)	
Deferred Tax Assets:		
Medical Claims Payable and Losses and Loss Adjustment Expense Reserves	$15,611	$10,502
Accruals Not Currently Deductible	16,125	16,542
Compensation Accruals	11,259	9,974
Bad Debt Allowances	3,140	4,091
Loss Carryforwards and Credits	28,696	59,756
Depreciation and Amortization	3,642	5,038
Unearned Premiums	2,976	1,757
Deferred Reinsurance Gains	1,806	2,022
Unrealized Investment (Gains) Losses	(777)	3,033
Other	844	190
Total	83,322	112,905
Deferred Tax Liabilities:		
Deferred Policy Acquisition Costs	758	741
Other	242	947
Total	1,000	1,688
Net Deferred Tax Asset	$ 82,322	$111,217

The tax effects of significant items comprising the net deferred tax assets of the Company's continuing operations are as follows at December 31:

	2002	2001
	(In thousands)	
Deferred Tax Assets:		
Medical Claims Payable	$ 4,587	$ 5,099
Accruals Not Currently Deductible	15,162	14,592
Compensation Accruals	10,772	9,190
Bad Debt Allowances	2,769	3,600
Loss Carryforwards and Credits	28,544	58,163
Unrealized Investment (Gains) Losses	(353)	645
Depreciation and Amortization	3,650	5,294
Other	218	243
Total	65,349	96,826
Deferred Tax Liabilities:		
Other	849	554
Total	849	554
Net Deferred Tax Asset	$ 64,500	$ 96,272

At December 31, 2002, the Company had approximately $75.9 million of regular tax net operating loss carryforwards. The net operating loss carryforwards can be used to reduce future taxable income until they expire through the year 2020. In addition to the net operating loss carryforwards, the Company has alternative minimum tax credits of approximately $848,000, which can be used to reduce regular tax liabilities in future years. There is no expiration date for the alternative minimum tax credits.

The Company, at a consolidated level including discontinued operations, does not have a valuation allowance at December 31, 2002 or 2001. Under the Company's tax sharing agreements, the discontinued operations do have a valuation allowance at December 31, 2002 and 2001, which is eliminated in the Company's consolidated financial statements.

Current tax receivables, including discontinued operations, total $2.3 million at December 31, 2002 and 2001.

8. TEXAS DISCONTINUED OPERATIONS

During the third quarter of 2001, the Company announced its plan to exit the Texas HMO health care market and received formal approval from the Texas Department of Insurance to withdraw its HMO operations in mid-October. The Company ceased providing HMO health care coverage in Texas on April 17, 2002.

The Company elected to early adopt SFAS No. 144 effective January 1, 2001. In accordance with SFAS No. 144, the Company's Texas HMO health care operations were reclassified as discontinued operations. The Company received a limited waiver under its revolving credit facility agreement for covenants affected by exiting the Texas HMO health care market.

The following are condensed statements of operations of the discontinued Texas HMO health care operations:

	Years ended December 31,

	2002	2001	2000
		(In thousands)	
Operating Revenues	$ 4,791	$ 181,132	$ 233,39
Medical Expenses	(8,933)	175,333	233,65
General and Administrative Expenses	1,906	29,607	31,34
Asset Impairment, Restructuring, Reorganization and Other Costs	5,000	(1,250)	186,60
Interest Expense and Other, Net	(6,216)	(1,532)	4,26
Income (Loss) from Discontinued Operations Before Income Tax.	13,034	(21,026)	(222,47
Income Tax (Provision) Benefit	(4,562)	7,046	61,35
Income (Loss) from Discontinued Operations	$ 8,472	$ (13,980)	$ (161,12

All of the discontinued Texas HMO health care operations had previously been a component of the "managed care and corporate operations" segment.

Included in the Texas HMO health care operations medical expenses for the year ended December 31, 2000, are $14.7 million, primarily for adverse development on prior periods' medical claims, and $15.5 million in premium deficiency medical expense related to under-performing markets in the Dallas/Ft. Worth and Houston areas. The recorded premium deficiency reflected anticipated costs after restructuring and reorganization actions taken in the first six months of 2000. During the second quarter of 2001, management revised their estimates of premium deficiency reserves and reclassified $7.8 million from premium deficiency maintenance reserve to premium deficiency medical reserve. This reclassification was based on the latest available medical cost trends, which did not become evident until late in the second quarter of 2001, and is reflected as an increase in medical expense and a decrease in general and administrative expenses on the condensed statements of operations of the discontinued Texas HMO health care operations.

Asset impairment, restructuring, reorganization and other costs for the year ended December 31, 2000 include the following: (a) asset impairment charges of $126.4 million for impaired goodwill; (b) $36.5 million for impaired real estate and other fixed assets; (c) $10.4 million for premium deficiency maintenance costs; and (d) other restructuring, reorganization and other costs of $13.3 million.

In conjunction with the Company's plan to exit the Texas HMO health care market, during the third quarter of 2001, the Company recorded charges of $10.6 million for premium deficiency medical costs, $1.6 million to write down certain Texas furniture and equipment, $2.0 million in lease and other termination costs, $1.8 million in legal and restitution costs, $500,000 in various other exit related costs and $570,000 in premium deficiency maintenance.

As part of the Company's continual evaluation of its remaining liabilities, it was determined during the second quarter of 2002, that the medical claims run out had been favorable compared with the Company's original projection and that legal and other costs were estimated to be higher than originally anticipated. As a result, during the second quarter, the Company reduced its medical claims payable and medical expenses by $5.0 million and increased its estimate of legal, restitution and other exit related costs by $5.0 million. During the third and fourth quarters, the Company continued to have favorable development in both medical claims and legal, restitution and other exit related costs. As a result, the Company reduced its estimate for medical claims payable by $4.8 million and for legal, restitution and other exit related costs by $4.2 million. The adjustments resulted in income, net of tax, from discontinued operations of $5.9 million. See also the discussion below for a description of the $2.6 million gain, net of tax, related to the Kaiser-Texas mortgage loan and sale of Texas real estate properties.

The table below presents a summary of discontinued Texas HMO health care operations' asset impairment, restructuring, reorganization and other cost activity for the periods indicated.

	Asset Impair-ment	Restructuring and Reorgan-ization	Premium Deficiency Maintenance	Other	Total
			(In thousands)		
Balance, January 1, 2000	$ --	$ --	$ 11,000	$ --	$ 11,000
Charges recorded	162,937	11,509	10,358	1,800	186,604
Cash used		(7,754)	(12,080)	(200)	(20,034
Noncash activity	(162,937)	--	--	(800)	(163,737
Changes in estimate	--	--	--	--	--
Balance, December 31, 2000	--	3,755	9,278	800	13,833
Charges recorded	1,600	4,380	570	--	6,550
Cash used	--	(3,716)	(1,478)	(800)	(5,994
Noncash activity	(1,600)	(125)	--	--	(1,725
Changes in estimate	--	--	(7,800)	--	(7,800
Balance, December 31, 2001	--	4,294	570	--	4,864
Charges recorded	--	--	--	--	--
Cash used	--	(2,490)	(570)	--	(3,060
Noncash activity	--	(4,222)	--	--	(4,222
Changes in estimate	--	5,000	--	--	5,000
Balance, December 31, 2002	$ --	$ 2,582	$ --	$ --	$ 2,582

The remaining restructuring and reorganization costs of $2.6 million are primarily due to legal and related costs and various lease and other exit related costs. Management believes that the remaining reserves, as of December 31, 2002, are appropriate and that no further revisions to the estimates are necessary at this time. Based on the current estimated Texas HMO health care run-out costs and recorded reserves, the Company believes it has adequate funds available and the ability to fund the anticipated obligations.

The following are the assets and liabilities of the discontinued Texas HMO health care operations:

	December 31,	
	2002	2001
	(In thousands)	
ASSETS		
Cash and Cash Equivalents	$ --	$ --
Investments	4,263	4,274
Other Assets	916	4,023
Property and Equipment, Net	11,967	20,107
TOTAL ASSETS	17,146	28,404
LIABILITIES		
Accounts Payable and Other Liabilities	9,059	16,475

Medical Claims Payable	1,754	36,567
Premium Deficiency Reserve	--	1,700
Mortgage Loan	14,961	29,189
TOTAL LIABLIITIES	25,774	83,931
NET LIABILITIES OF DISCONTINUED OPERATIONS	$ (8,628)	$ (55,527)

The assets and liabilities above do not include an intercompany liability of $38.4 million from Texas Health Choice, L.C., ("TXHC") to Sierra at December 31, 2002. The liability is secured by certain of the TXHC land and buildings and has been eliminated upon consolidation.

Property and equipment consists mainly of real estate properties located in the Dallas/Fort Worth metroplex areas. TXHC acquired these properties from Kaiser Foundation Health Plan of Texas ("Kaiser- Texas"), for $44.0 million as part of the acquisition of certain assets of Kaiser-Texas in October 1998. In June 2000, as part of its restructuring and reorganization of the Texas HMO health care operations, the Company announced its intention to sell these properties. The real estate was written down to its estimated fair value and the Company took an asset impairment charge of $27.0 million. The real estate is encumbered by a mortgage loan to Kaiser-Texas, which is guaranteed by Sierra.

During 2001, Sierra participated in negotiations with Kaiser- Texas relating to the real estate properties and associated mortgage loan to Kaiser-Texas along with other matters. Sierra reached an agreement with Kaiser- Texas, effective December 31, 2001, whereby Kaiser-Texas forgave $8.5 million of the outstanding principal balance of the mortgage loan and extended the maturity from November 1, 2003 to November 1, 2006. In exchange for the consideration by Kaiser-Texas, Sierra agreed to an unconditional guaranty of the mortgage loan. In conjunction with the agreement, Sierra applied a $2.5 million outstanding receivable from Kaiser-Texas to the outstanding balance of the mortgage loan on December 31, 2001.

In accordance with accounting principles generally accepted in the United States of America, the agreement was accounted for as a restructuring of debt. In the transaction, total future cash payments (interest and principal) were less than the balance of the mortgage loan at the time of the agreement. Accordingly, a gain on restructuring was recognized for the difference and the carrying amount of the mortgage loan is equal to the total future cash payments. Costs incurred in connection with the agreement were offset against the gain on restructuring. Effective January 1, 2002, all future cash payments, including interest, related to the mortgage loan are reductions of the carrying amount; therefore, no future interest expense will be recognized.

During 2002, TXHC sold four of the eight real estate properties and a piece of land for net proceeds of $8.8 million. The sales resulted in a gain on sale, net of tax, of $700,000. As required under the terms of the mortgage loan agreement, pre-determined minimum amounts of the mortgage note are required to be paid as each piece of real estate is sold. Accordingly total payments of $11.3 million were made to Kaiser-Texas on the mortgage loan. Since the principal payments resulted in a reduction of future interest, future accrued interest was reduced and a gain, net of tax, of $1.9 million was recorded. At December 31, 2002, the mortgage loan has a carrying value of $15.0 million, which consists of a principal balance of $12.7 million and $2.3 million in future accrued interest.

9. CII FINANCIAL, INC. DISCONTINUED OPERATIONS

On January 15, 2003, the Company announced that it is exploring strategic alternatives for its workers' compensation company, CII. The alternatives may include a sale, spin-off or management buyout. The disposal of the operations was approved by Sierra's Board of Directors on December 31, 2002. Accordingly, beginning in the fourth quarter of 2002, the Company reclassified its workers' compensation insurance business as discontinued operations. CII represented the majority of the Company's previous workers' compensation operations segment and specialty product

income and expenses. See Note 17 for a discussion of the recasted segment presentation.

In conjunction with the decision to dispose of the workers' compensation operations CII recorded valuation adjustments of $17.3 million, $11.3 million after tax, to reduce the operations to its estimated net realizable value upon disposition. The valuation adjustments included the write down of accounts receivable, fixed assets and certain other assets of $3.5 million, an investment valuation adjustment of $500,000 and additional loss reserves of $8.3 million for the 2002 accident year and $5.0 million for prior accident years. The Company received a limited waiver under its revolving credit facility agreement for covenants affected by this decision.

Summary of significant accounting policies related to workers' compensation operations.

Specialty Product Revenues.

These revenues consist of workers' compensation premiums. Premiums are calculated by formula such that the premium written is earned pro rata over the term of the policy. Premiums written in excess of premiums earned are recorded as an unearned premium revenue liability. Premiums earned include an estimate for earned but unbilled premiums.

Specialty Product Expenses.

These expenses consist primarily of losses and loss adjustment expense ("LAE"), policy acquisition costs and other general and administrative expenses associated with issued workers' compensation policies. Losses and LAE are based upon the accumulation of cost estimates for reported claims occurring during the period as well as an estimate for losses that have occurred but have not yet been reported. Policy acquisition costs consist of commissions, premium taxes and other underwriting costs, which are directly related to the production and retention of new and renewal business and are deferred and amortized as the related premiums are earned. Should it be determined that future policy revenues and earnings on invested funds relating to existing insurance contracts will not be adequate to cover related costs and expenses, deferred costs are expensed.

Loss and LAE reserves have a significant degree of uncertainty when related to their subsequent payments. Although reserves are established on the basis of a reasonable estimate, it is not only possible but probable that reserves will differ from their related subsequent developments. Underlying causes for this uncertainty include, but are not limited to, uncertainty in development patterns and unanticipated inflationary trends affecting the cost of services covered by the insurance contract. This uncertainty can result in both adverse as well as favorable development of actual subsequent activity when compared to the reserve established. Any subsequent change in loss and LAE reserves established in a prior year would be reflected in that subsequent year's operating results.

The following are the assets and liabilities of the discontinued operations of CII:

	December 31,	
	2002	2001
	(In thousands)	
ASSETS		
Cash and Cash Equivalents	$ 23,060	$ 8,641
Investments	287,242	231,987
Reinsurance Recoverable	189,409	218,079

Property and Equipment, Net	2,167	4,955
Other Assets	46,034	41,607
TOTAL ASSETS	547,912	505,269
LIABILITIES		
Accounts Payable and Other Accrued Expenses	30,989	28,919
Senior Debentures	16,765	18,187
Reserve for Loss and Loss Adjustment Expenses	427,192	385,705
TOTAL LIABILITIES	474,946	432,811
NET ASSETS OF DISCONTINUED OPERATIONS	$ 72,966	$ 72,458

The following are condensed statements of operations of the discontinued operations of CII:

	Years ended December 31,		
	2002	2001	2000
OPERATING REVENUES:	(In thousands)		
Specialty Product Revenues	$ 176,189	$ 173,215	$ 125,555
Investment and Other Revenues	12,633	14,786	14,409
Total Revenues	188,822	188,001	139,964
OPERATING EXPENSES:			
Specialty Product Expenses	209,601	183,666	145,827
Asset Impairment	--	--	3,000
Interest Expense and Other, Net	1,059	707	2,581
Total Operating Expenses	210,660	184,373	151,408
(Loss) Income from Discontinued Operations Before Income Tax	(21,838)	3,628	(11,444)
Income Tax Benefit (Provision)	7,506	(1,643)	3,670
Net (Loss) Income from Discontinued Operations	$ (14,332)	$ 1,985	$ (7,774)

All of the discontinued operations of CII were a component of the "workers' compensation operations" segment.

Property and equipment at December 31, consists of the following:

	2002	2001
	(In thousands)	
Land	$ 116	$ 116

Buildings and Improvements	1,522	2,350
Furniture, Fixtures and Equipment	70	2,620
Data Processing Equipment and Software	3,534	5,345
Software in Development and Construction in Progress	45	93
Less: Accumulated Depreciation	(3,120)	(5,569)
Property and Equipment, Net	$ 2,167	$ 4,955

The following table summarizes the investments of CII as of December 31, 2002:

	Amortized Cost	Unrealized Gains	Unrealiz Losses
Available-for-Sale Investments:		(In thousands)	
Classified as Current:			
U.S. Government and its Agencies	$ 164,404	$ 2,729	$ 42
Municipal Obligations	65,454	338	50
Corporate Bonds	19,830	49	1,91
Other	10,987	46	2
Total Debt Securities	260,675	3,162	2,86
Preferred Stock	5,939	210	2
Total Current	266,614	3,372	2,89
Classified as Restricted:			
U.S. Government and its Agencies	12,489	711	
Municipal Obligations	974	62	
Corporate Bonds	756	5	
Total Restricted	14,219	778	-
Total Available-for-Sale	$ 280,833	$ 4,150	$ 2,89
Held-to-Maturity Investments:			
Classified as Current:			
Corporate Bonds	$ 799	$ 3	$
Classified as Long-term:			
U.S. Government and its Agencies	662	10	
Municipal Obligations	328	25	
Corporate Bonds	1,749	113	
Total Long-term	2,739	148	-

Classified as Restricted:			
Municipal Obligations	637	49	
Corporate Bonds	974	39	
Total Restricted	1,611	88	-
Total Held-to-Maturity	$ 5,149	$ 239	$ -

The following table summarizes the investments of CII as of December 31, 2001:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealiz Losses
		(In thousands)	
Available-for-Sale Investments:			
Classified as Current:			
U.S. Government and its Agencies	$ 174,856	$ 1,129	$ 6,21
Municipal Obligations	2,087	30	5
Corporate Bonds	28,572	81	2,05
Total Debt Securities	205,515	1,240	8,31
Preferred Stock	5,871	34	2
Total Current	211,386	1,274	8,33
Classified as Restricted:			
U.S. Government and its Agencies	11,145	262	5
Municipal Obligations	977	12	1
Corporate Bonds	1,495	35	
Total Restricted	13,617	309	6
Total Available-for-Sale	$ 225,003	$ 1,583	$ 8,40
Held-to-Maturity Investments:			
Classified as Current:			
Corporate Bonds	$ 2,999	$ 22	$
Total Current	2,999	22	-
Classified as Long-term:			
U.S. Government and its Agencies	5,608		25
Municipal Obligations	328		1
Corporate Bonds	2,498	175	
Total Long-term	8,434	175	27
Classified as Restricted:			
U.S. Government and its Agencies	626	24	
Municipal Obligations	636		2
Corporate Bonds	1,114	42	
Total Restricted	2,376	66	2
Total Held-to-Maturity	$ 13,809	$ 263	$ 30

The contractual maturities of available-for-sale debt securities at December 31, 2002 are shown below:

	Amortized Cost	Fair Value
	(In thousands)	
Due in one year or less	$ 56,532	$ 56,835
Due after one year through five years	56,321	57,103
Due after five years through ten years	32,216	32,682
Due after ten years through fifteen years	15,061	15,595
Due after fifteen years	114,764	113,751
Total	$ 274,894	$ 275,966

Expected maturities may differ from contractual maturities because borrowers have the right to call or prepay obligations.

The contractual maturities of held-to-maturity investments at December 31, 2002 are shown below:

	Amortized Cost	Fair Value
	(In thousands)	
Due in one year or less	$ 1,274	$ 1,277
Due after one year through five years	2,248	2,400
Due after five years through ten years		
Due after ten years through fifteen years		
Due after fifteen years	1,627	1,711
Total	$ 5,149	$ 5,388

Expected maturities may differ from contractual maturities because borrowers have the right to call or prepay obligations.

Reinsurance.

CII has reinsurance agreements or treaties in effect with unrelated entities. Effective July 1, 1998, all claims with dates of injury occurring on or after that date were reinsured under a quota share and excess of loss agreement ("low level reinsurance"), with Travelers Indemnity Company of Illinois ("Travelers"). Travelers is rated AA and A++ by Fitch Ratings and the A.M. Best Company, respectively. The low level reinsurance provided quota share protection for 30% of the first $10,000 of each loss, and excess of loss protection of 75% of the next $40,000 of each loss, and 100% of the next $450,000 on a per occurrence basis. The maximum net loss retained on any one claim ceded under this treaty was $17,000. This agreement continued until June 30, 2000, when CII exercised an option for a twelve month extension relating to the run-off of policies in force as of June 30, 2000, which covered claims arising under such policies during the term of the extension.

In addition to the low level reinsurance, effective January 1, 2000, CII entered into a reinsurance contract that provided statutory (unlimited) coverage for workers' compensation claims in excess of $500,000 per occurrence. The contract is in effect for claims occurring on or after January 1, 2000 through December 31, 2002. There is a twelve month run out provision in the contract which the Company exercised. The reinsurer, National Union Fire Insurance Company, is rated AAA and A++ by Fitch Ratings and the A.M. Best Company, respectively.

Effective July 1, 2000, CII entered into a reinsurance contract with National Union Fire Insurance Company that provided $250,000 of coverage for workers' compensation claims in excess of $250,000 per occurrence. The contract was in effect for claims occurring on policies with effective dates beginning July 1, 2000 and thereafter and for claims incurred prior to July 1, 2001.

The low level reinsurance agreement was consummated early in the fourth quarter of 1998 but coverage was made retroactive to July 1, 1998. Therefore, this agreement contained both retroactive (covering claims occurring in the third calendar quarter of 1998) and prospective reinsurance coverage (covering claims occurring after September 30, 1998). In accordance with Statement of Financial Accounting Standards No. 113, "Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts" ("SFAS No. 113"), CII bifurcated the low level reinsurance agreement between the retroactive and prospective components due to the different accounting treatments for each respective piece. The amount by which the estimated ceded liabilities exceeded the amount paid for the retroactive coverage was reported as a deferred gain and is amortized to income as a reduction of incurred losses over the estimated remaining settlement period using the interest method. Any subsequent changes in estimated or actual cash flows related to the retroactive coverage are accounted for by adjusting the previously recorded deferred gain to the balance that would have existed had the revised estimate been available at the inception of the reinsurance transactions, with a corresponding charge or credit to income. CII recorded an adjustment to increase its deferred gain related to retroactive reinsurance coverage by $1.2 million, $3.0 million and $3.7 million in 2002, 2001 and 2000, respectively. For the years ended December 31, 2002, 2001 and 2000, CII amortized deferred gains of $1.9 million, $2.7 million and $5.2 million, respectively. Such amortization is included as a credit to specialty product expense on the accompanying condensed consolidated statements of operations.

In accordance with SFAS No. 113, losses ceded under prospective reinsurance reduce direct incurred losses and amounts recoverable are reported as an asset. At December 31, 2002 and 2001, the amount of reinsurance recoverable under prospective reinsurance contracts for unpaid loss and LAE was $169.0 million and $187.5 million, respectively. At December 31, 2002 and 2001, the amount of reinsurance recoverable under the retroactive reinsurance contract was $6.9 million and $8.8 million, respectively. The amount of reinsurance receivable for paid loss and LAE was $13.5 million and $21.8 million at December 31, 2002 and 2001, respectively.

Reinsurance contracts do not relieve CII from its obligations to claimants or policyholders. Failure of reinsurers to honor their obligations could result in losses to CII. CII evaluates the financial condition of its reinsurers to minimize its exposure to significant losses from reinsurer insolvencies. To date, CII has never had to write-off a reinsurance recoverable balance and no allowance for uncollectible amounts has been established. All of the reinsurance recoverables are due from reinsurers rated AA- and A+ or better by Fitch Ratings and the A.M. Best Company, respectively, and all amounts are considered to be collectible.

The following table provides workers' compensation prospective reinsurance information for the three years ended December 31, 2002:

Recoveries on Paid Losses/LAE	Change in Recoverable on Unpaid Losses/LAE	Premium Ceded

		(In thousands)	
Year Ended December 31, 2002:			
Low level reinsurance carrier	$ 60,314	$ (37,854)	$ (2,18
Excess of loss reinsurance carriers	2,308	19,403	2,61
Total	$ 62,622	$ (18,451)	$ 43
Year Ended December 31, 2001:			
Low level reinsurance carrier	$ 80,932	$ (40,430)	$ 9,13
Excess of loss reinsurance carriers	4,407	9,125	4,24
Total	$ 85,339	$ (31,305)	$ 13,38
Year Ended December 31, 2000:			
Low level reinsurance carrier	$ 53,408	$ 100,240	$ 74,07
Excess of loss reinsurance carriers	2,324	8,428	3,44
Total	$ 55,732	$ 108,668	$ 77,52

Losses and Loss Adjustment Expenses.

The following table provides a reconciliation of the beginning and ending reserve balances for workers' compensation unpaid losses and LAE. The loss estimates are subject to change in subsequent accounting periods and any change to the current reserve estimates would be accounted for in future results of operations in the period when the change occurs.

	2002	2001	2000
		(In thousands)	
Net Beginning Losses and LAE Reserve	$ 198,252	$ 155,797	$ 134,30
Net Provision for Insured Events Incurred in:			
Current Year	139,513	131,923	86,58
Prior Years	23,998	8,691	23,29
Total Net Provision	163,511	140,614	109,88
Net Payments for Losses and LAE Attributable to Insured Events Incurred in:			
Current Year	29,448	28,560	26,86
Prior Years	74,125	69,599	61,52
Total Net Payments	103,573	98,159	88,38
Net Ending Losses and LAE Reserve	258,190	198,252	155,79
Reinsurance Recoverable	169,002	187,453	218,75
Gross Ending Losses and LAE Reserve	$ 427,192	$ 385,705	$ 374,55

While management of the Company believes that current estimates are reasonable, significant adverse or favorable loss development could occur in the future.

During the years ended December 31, 2002, 2001 and 2000, the Company experienced prior year net adverse loss development of $24.0 million, $8.7 million and $23.3 million, respectively. Estimated losses and LAE incurred in accident years 1996 to 1999 have developed significantly primarily due to the continuation of increasing claim severity patterns on CII's California book of business. Many workers' compensation insurance carriers in California are also experiencing high claim severity. Factors influencing the higher claim severity include rising average temporary disability costs, the increase in the number of major permanent disability claims, medical inflation and adverse court decisions related to medical control of a claimant's treatment.

Long-Term Debt - Senior Debentures.

At September 30, 2000, CII Financial, Inc. had approximately $47.1 million of subordinated debentures outstanding that were due on September 15, 2001. These subordinated debentures were neither assumed nor guaranteed by Sierra and were subordinated to Sierra's credit facility debt. In December 2000, CII Financial commenced an offer to exchange the subordinated debentures for cash and/or new debentures. On May 7, 2001, CII Financial closed its exchange offer on $42.1 million of its outstanding subordinated debentures. CII Financial purchased $27.1 million in principal amount of subordinated debentures for $20.0 million in cash and issued $15.0 million in new 9½% senior debentures, due September 15, 2004, in exchange for $15.0 million in subordinated debentures. The remaining $5.0 million in subordinated debentures were paid at maturity.

The transaction was accounted for as a restructuring of debt; therefore all future cash payments, including interest, related to the debentures will be reductions of the carrying amount of the debentures and no future interest expense will be recognized. Accordingly, at December 31, 2002, the new 9½% senior debentures have a carrying amount of $16.8 million, which consists of principal amount of $14.0 million and $2.8 million in future accrued interest. Since the time of the exchange, Sierra has purchased $1.0 million in outstanding 9½% senior debentures which are eliminated upon consolidation.

The new 9½% senior debentures pay interest, which is due semi-annually on March 15 and September 15 of each year, commencing on September 15, 2001. The new 9½% senior debentures rank senior to outstanding notes payable from CII Financial to Sierra and CII Financial's guarantee of Sierra's revolving credit facility. The new 9½% senior debentures may be redeemed by CII Financial at any time at premiums starting at 110% and declining to 100% for redemptions after April 1, 2004. In the event of a change in control of CII Financial, the holders of the new 9½% senior debentures may require that CII Financial repurchase them at the then applicable redemption price, plus accrued and unpaid interest.

Intercompany Notes Receivable/Payable

. In connection with the exchange offer for the subordinated debentures, CII has promissory notes payable to Sierra aggregating $17.0 million and bearing interest at 9½% under which principal and interest are due on demand. These notes are subordinated to the 9½% senior debentures.

Also in connection with the exchange offer for the subordinated debentures, California Indemnity Insurance Company, a wholly owned subsidiary of CII Financial, Inc., loaned Sierra $7.5 million. The loan bears interest at 8.5%, which is due semi-annually on March 31 and September 30 of each year, commencing September 30, 2001. All outstanding principal and accrued interest is due on September 30, 2004. The loan is secured by the common stock of Sierra Health and Life Insurance Company Inc., a wholly owned subsidiary of Sierra, equal to 120% of the principal amount outstanding. The intercompany notes receivable/payable have been eliminated upon consolidation.

Asset Impairment.

During the second quarter of 2000, CII wrote-off capitalized costs of $3.0 million related to the application development of an information system software project for the workers' compensation operations, which was canceled

because the vendor was unable to fulfill its contractual obligations. The amounts written off included software and consulting costs of $1.6 million and capitalized internal personnel costs of $1.4 million.

10. COMMITMENTS AND CONTINGENCIES

Leases.

The Company is the lessee under several operating leases, most of which relate to office facilities and equipment. The rentals on these leases are charged to expense over the lease term as the Company becomes obligated for payment and, where applicable, provide for rent escalations based on certain costs and price index factors. The following is a schedule, by year, of the future minimum lease payments under existing operating leases:

Years Ended December 31,	**(In thousands)**
2003	$ 18,428
2004	17,819
2005	17,161
2006	16,603
2007	16,202
Thereafter	123,420
Total	$ 209,633

Rent expense totaled $15.8 million, $7.9 million and $7.2 million for the years ended December 31, 2002, 2001 and 2000, respectively.

The Company is a guarantor on a mortgage loan which has a carrying value of $15.0 million, consisting of a principal balance of $12.7 million and $2.3 million in future accrued interest. The mortgage loan is related to the property of the discontinued Texas HMO health care operations as described in Note 8.

Litigation and Legal Matters.

The Company is subject to various claims and other litigation in the ordinary course of business. Such litigation includes, but is not limited to, claims of medical malpractice, claims for coverage or payment for medical services rendered to HMO members and claims by providers for payment for medical services rendered to HMO and other members. Some litigation may also include claims for punitive damages that are not covered by insurance. Also included in such litigation are claims for workers' compensation and claims by providers for payment for medical services rendered to injured workers. These actions are in various stages of litigation and some may ultimately be brought to trial. With respect to certain pending actions, the Company maintains commercial insurance coverage with varying deductibles for which the Company maintains reserves for its self-insured portion based upon its current assessment of such litigation. Due to recent unfavorable changes in the commercial insurance market, the Company has, for certain risks, purchased coverage with higher deductibles and lower limits of coverage. In the opinion of management, based on information presently available, the ultimate resolution of these pending legal proceedings should not have a material adverse effect on our financial condition.

11. RELATED PARTY TRANSACTIONS

During 1997, the Company's Board of Directors authorized a $3.0 million loan from the Company to its Chief Executive Officer ("CEO"). In April 2000, the Company's Board of Directors authorized an additional $2.5 million loan from the Company to its CEO. In the second quarter of 2001, Sierra's Board of Directors approved a loan amendment which extended the maturity of the principal balance along with accrued interest to December 31, 2003. During 2002 and 2001, the CEO made payments of $1.0 million and $898,000 respectively. As of December 31, 2002, the aggregate principal balance outstanding and accrued interest for both instruments was $4.2 million. All amounts borrowed bear interest at a rate equal to the rate at which the Company could have borrowed funds under the revolving credit facility at the time of the borrowing plus 10 basis points. The amounts outstanding are collateralized by certain of the CEO's assets and rights to compensation from the Company. The loan is pledged as collateral under the Company's revolving credit facility.

The Company incurred legal fees of $24,000, $38,000 and $4,000 in the years ended December 31, 2002, 2001 and 2000 respectively, with a Nevada law firm of which a non-employee Board of Director member is a shareholder.

12. EMPLOYEE BENEFIT PLANS

Defined Contribution Plan.

The Company has a defined contribution pension and 401(k) plan (the "Plan") for its employees. The Plan covers all employees who meet certain age and length of service requirements. For the six months ended June 30, 1999, the Company contributed a maximum of 2% of eligible employees' compensation and matched 50% of a participant's elective deferral up to a maximum of either 10% of an employee's compensation or the maximum allowable under current IRS regulations. Effective July 1, 1999, the Plan was modified such that the Company matches 50%-100% of an employee's elective deferral up to a maximum of 6% of a participant's annual compensation, subject to IRS limits. The Plan does not require additional Company contributions. Expense under the plan totaled $4.4 million, $4.8 million and $4.7 million for the years ended December 31, 2002, 2001 and 2000, respectively.

Supplemental Retirement Plans.

The Company has Supplemental Retirement Plans (the "SRPs") for certain officers, directors and highly compensated employees. The SRPs are non-qualified deferred compensation plans through which participants may elect to postpone the receipt and taxation of all or a portion of their salary and bonuses received from the Company. Until July 1, 1999, the Company matched 50% of those contributions that participants were restricted from deferring, if any, under the Company's pension and 401(k) plan. As contracted with the Company, the participants or their designated beneficiaries may begin to receive benefits under the SRPs upon a participant's death, disability, retirement, termination of employment or certain other circumstances including financial hardship.

Executive Split Dollar Life Insurance Plan.

The Company has split dollar life insurance agreements with certain officers and key executives (selected and approved by the Sierra Board of Directors). The premiums paid by the Company will be reimbursed upon the occurrence of certain events as specified in the contract.

Supplemental Executive Retirement Plan ("SERP").

The Company has a defined benefit retirement plan covering certain key employees. The Company is informally funding the benefits through the purchase of life insurance policies. Benefits are based on, among other things, the employee's average earnings over the five-year period prior to retirement or termination, and length of service. Benefits attributable to service prior to the adoption of the plan are amortized over the estimated remaining service period for those employees participating in the plan.

A reconciliation of ending year SERP balances is as follows:

	Years ended December 31,		
	2002	2001	2000
	(In thousands)		
Changes in Projected Benefit Obligation:			
Projected Benefit Obligation at Beginning of Period	$ 19,143	$ 13,698	$ 12,81
Service Cost	292	322	36
Interest Cost	1,375	1,162	88
Actuarial Losses (Gains)	3,435	4,745	(17
Benefits Paid	(784)	(784)	(19
Projected Benefit Obligation at End of Period	$ 23,461	$ 19,143	$ 13,69
Fair Value of Plan Assets at End of Period (1)	$ --	$ --	$ -
Funded Status of the Plan	$ (23,461)	$ (19,143)	$ (13,69
Unrecognized Net Actuarial (Gain)/Loss	6,761	3,900	(68
Unrecognized Prior Service Credit	5,640	6,566	7,49
Accrued Net Benefit Costs	$ (11,060)	$ (8,677)	$ (6,89
Amounts Recognized in the Consolidated Balance Sheets:			
Accrued Net Benefit Costs	$ (11,060)	$ (8,677)	$ (6,89
Additional Minimum Liability	(7,270)	(7,773)	(3,45
Intangible Asset	5,640	7,773	3,45
Accumulated Other Comprehensive Loss	1,630	--	-
Net Liability Reflected in the Consolidated Balance Sheets:	$ (11,060)	$ (8,677)	$ (6,89
Assumptions:			
Discount Rate	6.5%	7.0%	7.
Rate of Compensation Increase	3.0%	3.0%	3.
Components of Net Periodic Benefit Cost:			
Service Cost	$ 292	$ 322	$ 36
Interest Cost	1,375	1,162	88
Amortization of Prior Service Credits	925	925	92
Recognized Actuarial Loss (Gain)	575	159	(2
Net Periodic Benefit Cost	$ 3,167	$ 2,568	$ 2,15

1. While the SERP is an unfunded plan, the Company is informally funding the plan through life insurance contracts on certain Company employees. The life insurance contracts had cash surrender values of $11.7 million, $10.3 million and $8.4 million at December 31, 2002, 2001 and 2000, respectively.

13. CAPITAL STOCK PLANS

Stockholders' Rights Plan.

Each share of Sierra common stock, par value $.005 per share, contains one right (a "Right"). Each Right entitles the registered holder to purchase from Sierra a unit consisting of one one-hundredth (.01) of a share of the Sierra Series A Junior Participating

Preferred Shares (a "Unit"), par value $.01 per share, or a combination of securities and assets of equivalent value, at a purchase price of $100.00 per Unit, subject to adjustment. The Rights have certain anti-takeover effects. The Rights will cause substantial dilution to a person or group that attempts to acquire Sierra on terms not approved by Sierra's Board of Directors, except pursuant to an offer conditioned on a substantial number of Rights being acquired. The Rights should not interfere with any merger or other business combination approved by the Board of Directors since Sierra may redeem the Rights at the price of $.02 per Right prior to or within ten days of the time that a person or group has acquired, or obtained the right to acquire, beneficial ownership of 20% or more of Sierra common stock.

Stock Option Plans.

The Company has several plans that provide common stock-based awards to employees and to non-employee directors. The plans provide for the granting of options, stock, and other stock-based awards. Awards are granted by a committee appointed by the Board of Directors. Options become exercisable at such times and in such installments as set by the committee. The exercise price of each option equals the market price of the Company's stock on the date of grant. Stock options generally vest at a rate of 20% - 33% per year. Options expire from one to eight years after the end of the vesting period.

The following table reflects the activity of the stock option plans:

	Number of Shares	Option Price	Weighted Average Price
	(Number of shares in thousands)		
Outstanding January 1, 2000	3,904	$6.31 - 24.69	$ 15.3
Granted	2,458	3.13 - 7.19	3.8
Canceled	(2,112)	3.75 - 24.69	18.1
Outstanding December 31, 2000	4,250	3.13 - 24.69	7.3
Granted	2,218	4.24 - 8.93	6.5
Exercised	(72)	3.75 - 8.00	5.2
Canceled	(393)	3.19 - 24.69	10.9
Outstanding December 31, 2001	6,003	3.13 - 24.69	6.8
Granted	944	8.13 - 13.17	10.8
Exercised	(995)	3.25 - 22.38	5.7
Canceled	(100)	3.25 - 24.69	11.3
Outstanding December 31, 2002	5,852	3.13 - 24.69	7.5
Exercisable at December 31, 2002	1,866	3.13 - 24.69	8.5
Available for Grant at December 31, 2002	1,462		

The following table summarizes information about stock options outstanding at December 31, 2002:

Weighted Average	Options	Weighted Average Exercise Price

Range of Exercise Price	Contractual Life Remaining in Days	Outstanding	Exercisable	Outstanding	Exercisable
$3.13 - 3.75	2,709	1,515	297	$ 3.71	$ 3.68
4.24 - 5.73	3,031	1,409	581	5.55	5.68
6.19 - 8.93	2,186	1,837	672	8.21	8.08
9.91 - 24.69	2,801	1,091	316	14.40	19.37

Employee Stock Purchase Plans.

The Company has an employee stock purchase plan (the "Purchase Plan") whereby employees may purchase newly issued shares of common stock through payroll deductions at 85% of the fair market value of such shares on specified dates as defined in the Purchase Plan. During 2002, a total of 670,000 shares were purchased at prices of $6.02 and $6.91 per share. During January 2003, 145,000 shares were purchased by employees at $10.21 per share in connection with the Purchase Plan. An additional 900,000 shares were reserved for issuance under the Purchase Plan at the annual meeting of stockholders on May 23, 2002. At December 31, 2002, the Company had 761,000 shares reserved for purchase under the Purchase Plan.

Restricted Stock Units.

The Company issued 244,000 restricted stock units ("units"), to certain executives during 2001. The first half of the units vest in 2003 with the remainder vesting in 2004. Each unit represents a nontransferable right to receive one share of Sierra stock and there is no cost by the recipient to exercise the units. The units are included in total outstanding common shares. In the calculation of earnings per share, the units are not included in the common shares outstanding but are included in the calculation of common shares outstanding assuming dilution. The transaction was recorded by including the value of the units as common stock and additional paid-in capital offset by a contra-equity account, deferred compensation. The value of the transaction was based on the number of units issued and the Company stock price on the date of issuance, which was $5.73. Compensation expense will be recognized over the period of vesting. Total expense associated with the plan was $585,000 and $342,000 for 2002 and 2001, respectively.

Accounting for Stock-Based Compensation.

The Company uses the intrinsic value method in accounting for its stock-based compensation plans. The fair value pro forma presentation presented in Note 2 was estimated at the date of grant using the Black-Scholes option pricing model with the following weighted average assumptions used for grants in 2002, 2001 and 2000, respectively: dividend yield of 0% for all years; expected volatility of 74%, 83% and 52%; risk-free interest rates of 3.32%, 4.34% and 6.60%; and expected lives of two to five years. The weighted average fair value of options granted in 2002, 2001 and 2000 was $8.60, $5.58 and $2.72, respectively.

The fair value of the look-back option implicit in each offering of the Purchase Plans is estimated on the date of grant using the Black-Scholes option pricing model with the following weighted average assumptions used for grants in 2002, 2001 and 2000, respectively: dividend yield of 0% for all years; expected volatility of 56%, 85% and 46%; risk-free interest rates of 1.48%, 4.36% and 5.79%; and expected lives of six months for all years.

14. CONSOLIDATED STATEMENTS OF CASH FLOWS SUPPLEMENTAL INFORMATION

Supplemental statements of cash flows information is presented below:

	Years ended December 31,		
	2002	2001	2000
	(In thousands)		
Cash Paid During the Year for Interest (Net of Amount Capitalized)	$ 7,205	$ 17,164	$ 23,704
Cash Received During the Year for Income Taxes	(12,796)	(221)	(10,615)

Non-cash Investing and Financing Activities:			
Retired Sale-Leaseback Assets, Liabilities and Financing Obligations	89,751	14,552	--
Note Received for Sale of Investment	--	--	3,700
Stock Issued for Exercise of Options and Related Tax Benefits	6,837	97	--
Additions to Capital Leases	--	--	1,835
Debentures Exchanged	--	19,692	--

15. CERTAIN MEDICAL EXPENSES

Included in reported medical expenses for 2000 are changes in estimate charges of $16.5 million of reserve strengthening primarily due to adverse development on prior periods' medical claims. In addition, the Company recorded $9.5 million of other non-recurring medical costs primarily relating to the write-down of medical subsidiary assets.

16. ASSET IMPAIRMENT, RESTRUCTURING, REORGANIZATION AND OTHER COSTS

Asset Impairments:

Management adopted a plan in the second quarter of 2000 to discontinue medical delivery operations in Mohave County, Arizona and to sell the real estate assets located there, as well as an underperforming medical clinic in Las Vegas.

In connection with the restructuring plans adopted and announced by the Company in the second quarter of 2000, the Company re-evaluated the recoverability of certain long-lived assets, in accordance with SFAS No. 121 and APB No. 17 and determined that the carrying values of certain goodwill and other long-lived assets were impaired.

In assessing the asset impairment of the long-lived assets, the Company first allocated a portion of related goodwill to the fixed assets to be disposed of, in accordance with SFAS No. 121. The fixed assets were then written down to estimated fair value less costs to sell, which was determined from independent valuations. The remainder of the related goodwill was then assessed for recoverability in accordance with APB No. 17 based on projected discounted cash flows.

The charges recorded for the write-off of goodwill totaled $15.1 million and related primarily to the Prime Holdings, Inc. acquisition. The charges recorded for fixed asset impairment totaled $9.5 million for the Arizona and Nevada operations.

Restructuring and Reorganization:

In the second quarter of 2000, the Company adopted a plan and announced additional restructuring of the Arizona managed health care operations. As a result of this restructuring, the Company recorded charges in accordance with Emerging Issues Task Force Issue No. 94-3, "Liability Recognition for Certain Employee Termination Benefits and Other Costs to Exit an Activity (Including Certain Costs Incurred in a Restructuring)" of approximately $2.0 million. Of the costs recorded, $1.2 million was for severance, $400,000 was related to clinic closures and lease termination and $400,000 was for other costs.

Other:

The $4.3 million of costs recorded in the second quarter of 2000 relate primarily to the write-down of certain receivables as well as an accrual for legal settlements.

The table below presents a summary of asset impairment, restructuring and other costs of continuing operations for the years indicated.

	Asset Impairment	Restructuring and Reorganization	Other	Total
		(In thousands)		
Balance, January 1, 2000	$ --	$ --	$ 3,449	$ 3,449
Charges recorded	24,553	1,983	4,300	30,836
Cash used	--	(1,389)	(302)	(1,691)
Noncash activity	(24,553)	--	(3,000)	(27,553)
Changes in estimate	--	--	--	--
Balance, December 31, 2000	--	594	4,447	5,041
Charges recorded	--	--	--	--
Cash used	--	(594)	--	(594)
Noncash activity	--	--	--	--
Changes in estimate	--	--	--	--
Balance, December 31, 2001	--	--	4,447	4,447
Charges recorded	--	--	--	--
Cash used	--	--	--	--
Noncash activity	--	--	(500)	(500)
Changes in estimate	--	--	--	--
Balance, December 31, 2002	$ --	$ --	$ 3,947	$ 3,947

The remaining other costs of $3.9 million are related to legal claims. Management believes that the remaining reserves, as of December 31, 2002, are appropriate and that no revisions to the estimates are necessary at this time.

17. SEGMENT REPORTING

The Company has two reportable segments based on the products and services offered: managed care and corporate operations, and military health services operations. The managed care segment includes managed health care services provided through HMO, managed indemnity plans, third-party administrative services programs for employer-funded health benefit plans and self-insured workers' compensation plans, multi-specialty medical groups, other ancillary services and corporate operations. The military health services segment administers a five-year, managed care federal contract for the Department of Defense's TRICARE program in Region 1.

Due to the classification of the workers' compensation insurance operations as discontinued operations in 2002, all amounts presented have been recast to conform with the two segment presentation at December 31, 2002.

The Company evaluates each segment's performance based on segment operating profit. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies (except as described in the notes below). Certain changes in estimate charges for the years ended December 31, 2001 and 2000 were reclassified to segment operation profit to conform with the current year presentation.

Information concerning the operations of the reportable segments is as follows:

	Managed Care and Corporate Operations	Military Health Services Operations	Total
		(In thousands)	
Year Ended December 31, 2002			
Medical Premiums	$ 857,741	$ --	$ 857,741
Military Contract Revenues	--	373,589	373,589
Professional Fees	30,923	--	30,923
Investment and Other Revenues	14,305	2,077	16,382
Total Revenue	$ 902,969	$ 375,666	$1,278,635
Segment Operating Profit	$ 56,700	$ 15,291	$ 71,991
Interest Expense Other	(7,455)	(32)	(7,487)
Other Income (Expense), Net	(309)	201	(108)
Income from Continuing Operations Before Income Taxes	$ 48,936	$ 15,460	$ 64,396
Segment Assets	$ 387,097	$ 113,811	$ 500,908
Capital Expenditures	(10,829)	(1,563)	(12,392)
Depreciation and Amortization	15,730	2,515	18,245
Year Ended December 31, 2001			
Medical Premiums	$ 718,994	$ --	$ 718,994
Military Contract Revenues	--	338,918	338,918
Professional Fees	28,985	--	28,985
Investment and Other Revenues	14,199	2,404	16,603
Total Revenue	$ 762,178	$ 341,322	$1,103,500
Segment Operating Profit	$ 30,798	$ 9,701	$ 40,499
Interest Expense Other	(15,693)	(93)	(15,786)
Other Income (Expense), Net	(2,175)	104	(2,071)
Income from Continuing Operations Before Income Taxes	$ 12,930	$ 9,712	$ 22,642
Segment Assets	$ 413,871	$ 117,302	$ 531,173
Capital Expenditures	5,759	1,377	7,136
Depreciation and Amortization (1)	20,159	4,025	24,184
Year Ended December 31, 2000			
Medical Premiums	$ 637,769	$ --	$ 637,769
Military Contract Revenues	--	330,352	330,352
Professional Fees	33,102	--	33,102
Investment and Other Revenues	17,488	905	18,393
Total Revenue	$ 688,359	$ 331,257	$1,019,616
Segment Operating Profit (2)	$ 25,412	$ 7,992	$ 33,404

Interest Expense Other	(17,511)	(354)	(17,865)
Other Income (Expense), Net	1,341	(257)	1,084
Changes in Estimate Charges (3)	(26,011)	--	(26,011)
Asset Impairment, Restructuring, Reorganization and Other Costs	(30,836)	--	(30,836)
(Loss) Income from Continuing Operations Before Income Taxes	$ (47,605)	$ 7,381	$ (40,224)
Segment Assets	$ 485,208	$ 115,520	$ 600,728
Capital Expenditures	13,957	717	14,674
Depreciation and Amortization (1)	21,219	2,926	24,145

- Goodwill amortization of $805,000 and $1,131,000 is included as part of the managed care and corporate operations segment for 2001 and 2000, respectively.
- The segment operating profit excludes the effects of asset impairment, restructuring, reorganization and other costs.
- Represents changes in estimate charges in the current year for services or liabilities of a prior year that are reclassified to Medical Expenses for presentation in accordance with accounting principles generally accepted in the United States of America.

18. GOODWILL

On January 1, 2002, the Company adopted Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets" ("SFAS No. 142"). SFAS No. 142 requires, among other things, the discontinuance of goodwill amortization. In addition, the pronouncement includes provisions for the reclassification of certain existing recognized intangibles as goodwill, reassessment of the useful lives of existing recognized intangibles, reclassification of certain intangibles out of previously reported goodwill and the identification of reporting units for purposes of assessing potential future impairments of goodwill. SFAS No. 142 also required the Company to complete a transitional goodwill impairment test six months from the date of adoption and at least annually thereafter. The net amortized goodwill balance at December 31, 2002, is $14.8 million. The Company completed its transitional goodwill test and determined that the recorded goodwill was not impaired under the guidelines of the pronouncement.

The following table presents the results of operations as though the adoption of SFAS No. 142 occurred as of January 1, 2000:

Year Ended December 31, 2001

	As Reported	Adjustments for Amortization of Goodwill	As Adjusted
	(In thousands, except per share data)		
Income from Continuing Operations	$ 15,481	$ 523	$ 16,004
Loss from Discontinued Operations	(11,995)	--	(11,995)
Net Income	$ 3,486	$ 523	$ 4,009
Earnings per Common Share:			
Income from Continuing Operations	$ 0.56	$ 0.02	$ 0.58
Loss from Discontinued Operations	(0.43)	--	(0.43)
Net Income	$ 0.13	$ 0.02	$ 0.15
Earnings per Common Share Assuming Dilution:			

Income from Continuing Operations.....	$ 0.54	$ 0.02	$ 0.56
Loss from Discontinued Operations.....	(0.42)	--	(0.42)
Net Income.....	$ 0.12	$ 0.02	$ 0.14

Year Ended December 31, 2000

	As Reported	Adjustments for Amortization of Goodwill	As Adjusted
	(In thousands, except per share data)		
(Loss) Income from Continuing Operations.....	$ (31,019)	$ 735	$ (30,284)
(Loss) Income from Discontinued Operations...	(168,896)	1,100	(167,796)
Net (Loss) Income.....	$ (199,915)	$ 1,835	$ (198,080)
Earnings per Common Share:			
(Loss) Income from Continuing Operations.....	$ (1.15)	$ 0.03	$ (1.12)
(Loss) Income from Discontinued Operations...	(6.22)	0.04	(6.18)
Net (Loss) Income.....	$ (7.37)	$ 0.07	$ (7.30)
Earnings per Common Share Assuming Dilution:			
(Loss) Income from Continuing Operations.....	$ (1.15)	$ 0.03	$ (1.12)
(Loss) Income from Discontinued Operations...	(6.22)	0.04	(6.18)
Net (Loss) Income.....	$ (7.37)	$ 0.07	$ (7.30)

19. SUBSEQUENT EVENTS

On January 7, 2003, the Company announced that the Board of Directors authorized a program for the repurchase of up to 2.0 million shares of the Company's common stock. On February 25, 2003, the Company announced that it had repurchased approximately 600,000 shares of its common stock and that its Board of Directors had authorized it to purchase up to an additional 600,000 shares of Sierra common stock under its share repurchase program. Such purchases have been made from time to time at prevailing prices in the open market, by block purchase or in private transactions. As of March 6, 2003, the Company had purchased a total of 2.2 million shares for $27.6 million (see debenture use of proceeds below).

In March 2003, the Company issued $115 million aggregate principal amount of 2¼% senior convertible debentures due March 15, 2023. The Company used the net proceeds of the offering to repay the $39 million outstanding under its existing amended and restated credit facility and to contribute $35.0 million to SMHS in furtherance of its bid for the TRICARE Next Generation contract. The Company also used $19.9 million of the proceeds to purchase 1.6 million shares of Sierra common stock under its repurchase program. The remainder of the net proceeds will be used for working capital and general corporate purposes, including, subject to board approval, additional share repurchases.

The debentures are convertible, at the option of the holders, into shares of Sierra Health Services, Inc. common stock at a conversion price of $18.29, upon certain conditions including the sale price of Sierra's common stock exceeding 120% of the conversion price at specified times. The debentures are puttable to the Company for cash or Sierra common stock, at the Company's election, on March 15 in 2008, 2013 and 2018 and upon certain corporate events

including a change in control. The debentures can be called for cash beginning on March 20, 2008.

Also on March 3, 2003, the Company issued a new $65 million revolving credit facility which replaces the amended and restated credit facility. The new facility may be increased up to an aggregate amount of $125.0 million upon receipt of new commitments from existing or additional lenders. Interest on the facility is initially LIBOR plus 2.25%. The facility will expire on April 30, 2006 but can be extended, at the sole discretion of each of the lenders, until March 3, 2008. The new facility is available for general corporate purposes.

The new credit facility is secured by guarantees by certain of the Company's subsidiaries and a first priority perfected security interest in (i) all the capital stock of each of the unregulated, material domestic subsidiaries (direct or indirect) as well as all of the capital stock of certain regulated, material domestic subsidiaries and (ii) all other present and future assets and properties of those subsidiaries that guarantee the credit agreement obligations (including, without limitation, accounts receivable, inventory, real property, equipment, contracts, trademarks, copyrights, patents, license rights and general intangibles) subject, in each case to the exclusion of the capital stock of CII Financial, Inc. or any of its subsidiaries and certain other exclusions.

20. UNAUDITED QUARTERLY INFORMATION

Quarter Ended 2002:	March 31	June 30	September 30	D
	(In thousands, except per share d			
Operating Revenues as Reported	$ 348,580	$ 363,968	$ 381,324	$
Reclassification for Discontinued Operations	44,832	47,000	50,307	
Operating Revenues	303,748	316,968	331,017	
Operating Income from Continuing Operations as Reported	13,976	17,777	19,561	
Reclassification for Discontinued Operations	463	(31)	(1,464)	
Operating Income from Continuing Operations	13,513	17,808	21,025	
Income from Continuing Operations as Reported	7,381	10,523	12,135	
Reclassification for Discontinued Operations	239	(20)	(259)	
Income from Continuing Operations	7,142	10,543	12,394	
Net Income	$ 7,381	$ 10,523	$ 14,063	$
Basic earnings per share:				
Income from Continuing Operations as Reported	$ 0.26	$ 0.37	$ 0.42	$
Reclassification for Discontinued Operations	0.01	--	--	
Income from Continuing Operations	0.25	0.37	0.42	
Net Income	$ 0.26	$ 0.37	$ 0.48	$
Diluted earnings per share:				

Income from Continuing Operations as Reported.....	$ 0.25	$ 0.34	$ 0.38	$
Reclassification for Discontinued Operations.....	0.01	--	(0.01)	
Income from Continuing Operations.....	0.24	0.34	0.39	
Net Income.....	$ 0.25	$ 0.34	$ 0.44	$

Quarter Ended 2001:	March 31	June 30	September 30	D
	(In thousands, except per share d			
Operating Revenues as Reported.....	$ 303,228	$ 318,327	$ 330,854	$
Reclassification for Discontinued Operations.....	43,385	46,076	50,061	
Operating Revenues.....	259,843	272,251	280,793	
Operating Income from Continuing Operations as Reported	10,062	11,391	10,758	
Reclassification for Discontinued Operations.....	1,021	1,931	545	
Operating Income from Continuing Operations.....	9,041	9,460	10,213	
Income from Continuing Operations as Reported.....	3,466	3,777	4,572	
Reclassification for Discontinued Operations.....	(84)	1,711	277	
Income from Continuing Operations.....	3,550	2,066	4,295	
Net Income (Loss).....	$ 3,205	$ 2,795	$ (7,554)	$
Basic earnings per share:				
Income from Continuing Operations as Reported.....	$ 0.13	$ 0.14	$ 0.16	$
Reclassification for Discontinued Operations.....	--	0.06	0.01	
Income from Continuing Operations.....	0.13	0.08	0.15	
Net Income (Loss).....	$ 0.12	$ 0.10	$ (0.27)	$
Diluted earnings per share:				
Income from Continuing Operations as Reported.....	$ 0.13	$ 0.13	$ 0.16	$
Reclassification for Discontinued Operations.....	--	0.06	0.01	
Income from Continuing Operations.....	0.13	0.07	0.15	
Net Income (Loss).....	$ 0.12	$ 0.10	$ (0.26)	$

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

PART III

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT

The information set forth under the caption "Election of Directors" in Sierra's Proxy Statement for its 2002 Annual Meeting of Stockholders, is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information set forth under the caption "Compensation of Executive Officers" in Sierra's Proxy Statement for its 2003 Annual Meeting of Stockholders, is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

The information set forth under the caption "Security Ownership of Certain Beneficial Owners and Management" in Sierra's Proxy Statement for its 2003 Annual Meeting of Stockholders, is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

The information set forth under the caption "Certain Relationships and Related Transactions" in Sierra's Proxy Statement for its 2003 Annual Meeting of Stockholders, is incorporated herein by reference.

ITEM 14. CONTROLS AND PROCEDURES

An evaluation of the effectiveness of the design and operation of the Company's disclosure controls and procedures as of a date within 90 days of this annual report was carried out by the Company under the supervision and with the participation of the Company's management, including the Chief Executive Officer and Chief Financial Officer. Based on that evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that the Company's disclosure controls and procedures have been designed and are effective to provide reasonable assurance that the information required to be disclosed by the Company in reports filed under the Securities and Exchange Act of 1934 is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms. A controls system, no matter how well designed and operated, cannot provide absolute assurance that the objectives of the controls system are met, and no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, within a company have been detected. Subsequent to the date of the most recent evaluation of the Company's internal controls, there was no significant changes in the Company's internal controls or in other factors that could significantly affect the internal controls, including any corrective actions with regard to significant deficiencies and material weaknesses.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES AND REPORTS ON FORM 8-K

(a)(1) The following consolidated financial statements are included in Part II, Item 8 of this Report:

(a)(2) Financial Statement Schedules:

All other schedules are omitted because they are not applicable, not required, or because the required information is in the consolidated financial statements or notes thereto.

(a)(3) The following exhibits are filed as part of, or incorporated by reference into, this Report as required by Item 601 of Regulation S-K:

(3.1) Articles of Incorporation, together with amendments thereto to date, incorporated by reference to Exhibit 4 (b) to the Registrant's Registration Statement on Form S-8 (No. 33-41543) effective July 3, 1991.

(3.2) Certificate of Division of Shares into Smaller Denominations of the Registrant, incorporated by reference to Exhibit 3.2 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2001.

(3.3) Amended and Restated Bylaws of the Registrant, as amended through March 21, 2002, incorporated by reference to Exhibit 3.3 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2001.

(3.4) Certificate pursuant to NRS Section 78.207 increasing the number of authorized shares of common stock to 60,000,000 pursuant to the Company's stock split on May 18, 1998, incorporated by reference to Exhibit 3.4 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2001.

(4.1) Rights Agreement, dated as of June 14, 1994, between the Registrant and Continental Stock Transfer & Trust Company, incorporated by reference to Exhibit 3.4 to the Registrant's Registration Statement on Form S-3 effective October 11, 1994 (Reg. No. 33-83664).

(4.2) Rights Agreement, dated as of June 14, 1994, amended as of August 10, 2000, between the Registrant and Wells Fargo Bank Minnesota, N.A, incorporated by reference to Exhibit 4.2 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2001.

(4.3) Specimen Common Stock Certificate, incorporated by reference to Exhibit 4.3 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2001.

(10.1) Form of Contract With Eligible Medicare+Choice Organization and the Centers for Medicare and Medicaid Services for the period January 1, 2001 to December 31, 2001, incorporated by reference to Exhibit 10.1 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2001.

(10.2) Amended and Restated Credit Agreement dated as of December 15, 2000, among Sierra Health Services, Inc. as Borrower, Bank of America National Trust and Savings Association as Administrative Agent and Issuing Bank, First Union National Bank as Syndication Agent, and the Other Financial Institutions Party Thereto, incorporated by reference to Exhibit 1 to the Registrant's Current Report on Form 8-K filed December 22, 2000.

(10.3) Form of Indenture for 9 1/2% senior debentures due September 15, 2004 from CII Financial, Inc. to Wells Fargo Bank Minnesota, N.A., as Trustee, incorporated by reference to Exhibit 4.3 to CII Financial's Registration Statement on Form S-4 (File No. 333-52726)

(10.4) Specimen 9 1/2% senior debenture due September 15, 2004 of CII Financial (included in Exhibit 10.3 hereto)

(10.5) Credit Agreement dated as of March 3, 2003, among Sierra Health Services, Inc. as Borrower, Bank of America N.A. as Administrative Agent and L/C Issuer, Credit Lyonnais New York Branch as Syndication Agent, U.S. Bank National Association as Documentation Agent and Banc of America as Sole Lead Arranger and Sole Book Manager.*

(10.6) Compensatory Plans, Contracts and Arrangements.

(1) Employment Agreement with Jonathon W. Bunker dated February 1, 2003.

(2) Employment Agreement with Frank E. Collins dated November 16, 2000, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(3) Employment Agreement with William R. Godfrey dated December 10, 1999, incorporated by reference to Exhibit 10.8 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1999.

(4) Employment Agreement with Laurence S. Howard dated December 10, 1999 incorporated by reference to Exhibit 10.8 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1999.

(5) Employment Agreement with Anthony M. Marlon, M.D. dated November 16, 2000, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(6) Employment Agreement with Erin E. MacDonald dated June 1, 2001, incorporated by reference to Exhibit 10.1 to Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2001.

(7) Employment Agreement with Michael A. Montalvo dated January 1, 2003.

(8) Employment Agreement with Marie H. Soldo dated November 16, 2000, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(9) Employment Agreement with Paul H. Palmer dated December 1, 2001, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2001.

(10) Form of Split Dollar Life Insurance Agreement effective as of August 25, 1998, by and between Sierra Health Services, Inc., and Jonathon W. Bunker, Ria Marie Carlson, Frank E. Collins, William R. Godfrey, Laurence S. Howard, Erin E. MacDonald, Anthony M. Marlon, M.D., Kathleen M. Marlon, Michael A. Montalvo, John A. Nanson, M.D., Paul H. Palmer and Marie H. Soldo, incorporated by reference to Exhibit 10.5 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(11) Sierra Health Services, Inc. Deferred Compensation Plan effective May 1, 1996 as Amended and Restated Effective January 1, 2001.

(12) Sierra Health Services, Inc. Supplemental Executive Retirement Plan effective July 1, 1997, as Amended and Restated January 1, 2001, incorporated by reference to Exhibit 10.5 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(13) Sierra Health Services, Inc. Supplemental Executive Retirement Plan effective as of March 1, 1998, incorporated by reference to Exhibit 10 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 1998.

(14) The Registrant's Second Amended and Restated 1986 Stock Option Plan as amended to date, incorporated by reference to Exhibit 4 (a) to the Registrant's Registration Statement on Form S-8 (No. 33-41543) effective July 3, 1991.

(15) Amendment No. 1 to The Registrant's Second Amended and Restated 1986 Stock Option Plan as amended to November 11, 1992, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2001.

(16) Amendment No. 2 to The Registrant's Second Amended and Restated 1986 Stock Option Plan as amended to March 16, 1993, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended

December 31, 2001.

(17) Sierra Health Services, Inc. Management Incentive Compensation Plan incorporated by reference to Exhibit 10.8 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1999.

(18) Sierra Health Services, Inc. 1995 Long-Term Incentive Plan, as amended and restated through December 11, 2001, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2001.

(19) Sierra Health Services, Inc. 1995 Non-Employee Directors' Stock Plan, as amended and restated through August 10, 2000, incorporated by reference to Exhibit 10.7 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2000.

(10.7) Loan Agreement dated August 11, 1997 between the Company and Anthony M. Marlon for a revolving credit facility in the maximum aggregate amount of $3,000,000, incorporated by reference to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 1997.

(10.8) Amendment No. 1 to Loan Agreement dated August 11, 1997 between the Company and Anthony M. Marlon for a revolving credit facility in the maximum aggregate amount of $3,000,000, incorporated by reference to Exhibit 10.8 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(10.9) Amendment No. 2 to Loan Agreement dated August 11, 1997 between the Company and Anthony M. Marlon for a revolving credit facility in the maximum aggregate amount of $3,000,000, incorporated by reference to Exhibit 10.9 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(10.10) Loan Agreement dated April 10, 2000 between the Company and Anthony M. Marlon for a term loan of $2,500,000, incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2000.

(10.11) Collateral Assignment of Rights dated April 10, 2000 between the Company and Anthony M. Marlon, incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2000.

(10.14) Settlement Agreement and Release of Claims between Kaiser Foundation Health Plan of Texas and Sierra Health Services, Inc. and certain subsidiaries, incorporated by reference to Exhibit 10.14 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2001.

(21) Subsidiaries of the Registrant (listed herein):

There is no parent of the Registrant. The following is a listing of the active subsidiaries of the Registrant:

	Jurisdiction of Incorporation
Sierra Health and Life Insurance Company, Inc.	California
Health Plan of Nevada, Inc.	Nevada
Sierra Health-Care Options, Inc.	Nevada
Behavioral Healthcare Options, Inc.	Nevada
Family Health Care Services	Nevada
Family Home Hospice, Inc.	Nevada
Southwest Medical Associates, Inc.	Nevada
Sierra Medical Management, Inc. and Subsidiaries	Nevada
Southwest Realty, Inc.	Nevada
Sierra Health Holdings, Inc. (Texas Health Choice, L.C.)	Nevada (Texas)
CII Financial, Inc., and Subsidiaries	California
Northern Nevada Health Network, Inc.	Nevada
Intermed, Inc.	Arizona
Sierra Military Health Services, Inc.	Delaware
Sierra Home Medical Products, Inc.	Nevada
Nevada Administrators, Inc.	Nevada

(23.1) Consent of Deloitte & Touche LLP

(99.1) Certification pursuant to 18 U.S.C. as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 of Principal Executive Officer dated September 21, 2003.

(99.2) Certification pursuant to 18 U.S.C. as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 of Principal Financial Officer dated September 21, 2003.

All other Exhibits are omitted because they are not applicable.

(b) Reports on Form 8-K

Current Report on Form 8-K, filed October 18, 2002, with the Securities and Exchange Commission in connection with the announcement of the Company's participation in a health care conference on October 28, 2002.

(d) Financial Statement Schedules

The Exhibits set forth in Item 15 (a)(2) are filed herewith.

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*The agreement contains certain schedules and exhibits which were not included in this filing. The Company will furnish supplementally a copy of any omitted schedule or exhibit to the Commission upon request.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has caused this report to be signed on its behalf by the undersigned thereto duly authorized.

SIERRA HEALTH SERVICES, INC.

By: /s/ Anthony M. Marlon, M.D.
Anthony M. Marlon, M.D.

Date: March 24, 2003

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Anthony M. Marlon, M.D. Anthony M. Marlon, M.D.	Chief Executive Officer and Chairman of the Board (Chief Executive Officer)	March 24, 2003
/s/ Paul H. Palmer Paul H. Palmer	Senior Vice President of Finance, Chief Financial Officer, and Treasurer (Chief Accounting Officer)	March 24, 2003
/s/ Erin E. MacDonald Erin E. MacDonald	Director	March 24, 2003
/s/ Charles L. Ruthe Charles L. Ruthe	Director	March 24, 2003
/s/ William J. Raggio William J. Raggio	Director	March 24, 2003
/s/ Thomas Y. Hartley Thomas Y. Hartley	Director	March 24, 2003
/s/ Michael E. Luce	Director	March 24, 2003

Michael E. Luce

/s/ Anthony L. Watson Director March 24, 2003

Anthony L. Watson

CERTIFICATION

I, Anthony M. Marlon, M.D., Chief Executive Officer, certify that:

1. I have reviewed this annual report on Form 10-K of Sierra Health Services, Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this annual report;

3. Based on my knowledge, the financial statements, and other financial information included in this annual report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this annual report;

4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedure (as defined in Exchange Act Rules 13a-14 and 15d-14) for the registrant and we have:

a. designed such disclosure controls and procedures to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this annual report is being prepared;

b. evaluated the effectiveness of the registrant's disclosure controls and procedures as of a date within 90 days prior to the filing date of this annual report (the "Evaluation Date"); and

c. presented in this annual report our conclusions about the effectiveness of the disclosure controls and procedures based on our evaluation as of the Evaluation Date;

5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

a. all significant deficiencies in the design or operation of internal controls which could adversely affect the registrant's ability to record, process, summarize and report financial data and have identified for the registrant's auditors any material weaknesses in internal controls; and

b. any fraud, whether or not material, that involves management or other employees who have significant role in the registrant's internal controls; and

6. The registrant's other certifying officers and I have indicated in this annual report whether or not there were significant changes in internal controls or in other factors that could significantly affect internal controls subsequent to the date of our most recent evaluation, including my corrective actions with regard to significant deficiencies and material weaknesses.

Date: March 24, 2003

/s/ Anthony M. Marlon

Anthony M. Marlon
Chief Executive Officer

CERTIFICATION

I, Paul H. Palmer, Chief Financial Officer, certify that:

1. I have reviewed this annual report on Form 10-K of Sierra Health Services, Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this annual report;

3. Based on my knowledge, the financial statements, and other financial information included in this annual report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this annual report;

4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedure (as defined in Exchange Act Rules 13a-14 and 15d-14) for the registrant and we have:

a. designed such disclosure controls and procedures to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this annual report is being prepared;

b. evaluated the effectiveness of the registrant's disclosure controls and procedures as of a date within 90 days prior to the filing date of this annual report (the "Evaluation Date"); and

c. presented in this annual report our conclusions about the effectiveness of the disclosure controls and procedures based on our evaluation as of the Evaluation Date;

5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

a. all significant deficiencies in the design or operation of internal controls which could adversely affect the registrant's ability to record, process, summarize and report financial data and have identified for the registrant's auditors any material weaknesses in internal controls; and

b. any fraud, whether or not material, that involves management or other employees who have significant role in the registrant's internal controls; and

6. The registrant's other certifying officers and I have indicated in this annual report whether or not there were significant changes in internal controls or in other factors that could significantly affect internal controls subsequent to the date of our most recent evaluation, including my corrective actions with regard to significant deficiencies and material weaknesses.

Date: March 24, 2003

/s/ Paul H. Palmer

Paul H. Palmer
Chief Financial Officer

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
SCHEDULE I - CONDENSED FINANCIAL INFORMATION OF REGISTRANT
CONDENSED BALANCE SHEETS - Parent Company Only

	Decem
	2002
ASSETS	(In tho
CURRENT ASSETS:	
Cash and Cash Equivalents	$ 1,751
Short-term Investments	1,747
Current Portion of Deferred Tax Asset	40,444
Prepaid Expenses and Other Current Assets	23,433
Total Current Assets	67,375
PROPERTY AND EQUIPMENT - NET	35,430
EQUITY IN NET ASSETS OF SUBSIDIARIES	134,989
NOTES RECEIVABLE FROM SUBSIDIARIES	9,246
GOODWILL	2,154

DEFERRED TAX ASSET	13,394
OTHER	29,469
TOTAL ASSETS	$ 292,057

LIABILITIES AND STOCKHOLDERS' EQUITY

CURRENT LIABILITIES:	
Accounts Payable and Other Accrued Liabilities	$ 21,105
Current Portion of Long-term Debt	83
Total Current Liabilities	21,188
LONG-TERM DEBT (Less Current Portion)	67,551
OTHER LIABILITIES	46,753
TOTAL LIABILITIES	135,492
STOCKHOLDERS' EQUITY:	
Capital Stock	155
Treasury Stock	(17,148)
Additional Paid-in Capital	196,711
Deferred Compensation	(473)
Accumulated Other Comprehensive Gain (Loss)	381
Accumulated Deficit	(23,061)
TOTAL STOCKHOLDERS' EQUITY	156,565
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 292,057

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
SCHEDULE I - CONDENSED FINANCIAL INFORMATION OF REGISTRANT (Continued)
CONDENSED STATEMENT OF OPERATIONS - Parent Company Only

	Year
	2002
REVENUES:	
Management Fees	$ 81,363
Subsidiary Dividends	20,000
Investment and Other Income	698
Total Revenues	102,061
EXPENSES:	
Depreciation	10,699
Other	36,186
Asset Impairment, Restructuring, Reorganization and Other Costs	--

Interest Expense and Other, Net	8,017
Total Expenses	54,902
INCOME BEFORE INCOME TAXES	47,159
INCOME TAX (PROVISION) BENEFIT	(8,615)
INCOME (LOSS) OF PARENT COMPANY	38,544
EQUITY IN UNDISTRIBUTED INCOME (LOSS) OF SUBSIDIARIES FROM CONTINUING OPERATIONS	3,764
INCOME (LOSS) FROM CONTINUING OPERATIONS	42,308
INCOME (LOSS) FROM DISCONTINUED OPERATIONS	(5,860)
NET INCOME (LOSS)	$ 36,448

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
SCHEDULE I - CONDENSED FINANCIAL INFORMATION OF REGISTRANT (Continued)
CONDENSED STATEMENTS OF CASH FLOWS - Parent Company Only

	Years
	2002
CASH FLOWS FROM OPERATING ACTIVITIES:	
Net Income (Loss) From Continuing Operations	$ 42,308
Adjustments to Reconcile Net Income (Loss) to Net Cash Provided by (Used for) Operating Activities:	
Depreciation and Amortization	10,699
Deferred Compensation	585
Provision for Property Impairment	--
Equity in Undistributed Income (Loss) of Subsidiaries Continuing Operations	3,764
Change in Assets and Liabilities	(51,053)
Net Cash Provided by (Used for) Operating Activities	6,303
CASH FLOWS FROM INVESTING ACTIVITIES:	
Capital Expenditures	(5,273)
Property and Equipment Dispositions	144
(Increase) Decrease in Investments	(117)
Dividends from Subsidiaries	20,000
Net Cash (Used for) Provided by Investing Activities	14,754
CASH FLOWS FROM FINANCING ACTIVITIES:	
Proceeds from Long-term Borrowing	--
Proceeds of Sale Leaseback Deposit	9,462

Reductions in Long-term Obligations and Payments on Capital Leases	(38,927)
Notes Receivable from Subsidiaries	--
Exercise of Stock in Connection with Stock Plans	10,159
Net Cash (Used for) Provided by Financing Activities	(19,306)
Net Increase (Decrease) in Cash and Cash Equivalents	1,751
Cash and Cash Equivalents at Beginning of Year	--
Cash and Cash Equivalents at End of Year	$ 1,751
Supplemental condensed statements of cash flows information:	
Cash Paid During the Year for Interest (Net of Amount Capitalized)	$ 11,559
Cash Received During the Year for Income Taxes	(13,051)
Noncash Investing and Financing Activities:	
Stock Issued for Exercise of Options and Related Tax Benefits	6,837
Retired Sale-Leaseback Assets, Liabilities and Financing Obligations	89,751
Addition to capital leases	--

1. LONG-TERM DEBT

Scheduled maturities of long-term debt, including the principal portion of obligations under capital leases, are as follows:

(In thousands)

December 31,	
2003	$ 83
2004	7,551
2005	--
2006	60,000
2007	--
Thereafter	--
Total	$ 67,634

2. OTHER

Reclassifications. Amounts related to our discontinued operations were reclassified to conform with the current year presentation in the Condensed Financial Information of Registrant for the years ended December 31, 2001 and 2000.

Management Fees. Sierra Health Services, Inc. receives monthly management fees from certain wholly-owned subsidiaries for services performed. The majority of the fees are from Health Plan of Nevada, Inc. under an administrative services agreement that has been approved by the Nevada Division of Insurance. The fees have been recorded as revenue in the Condensed Financial Information of Registrant for the three years ended December 31, 2002.

SIERRA HEALTH SERVICES, INC.
SUPPLEMENTAL INFORMATION
CONCERNING PROPERTY - CASUALTY INSURANCE
(In thousands)

Affiliation With Registrant Column A	Deferred Policy Acquisition Costs Column B	Gross Reserves for Unpaid Claims and Adjustment Expenses Column C	Discount if any Deducted in Column C Column D	Unearned Premiums Column E	Gross Earned Premiums Column F	Net Investment Income Column
Consolidated Property and Casualty Entities of CII Financial, Inc. for Years Ended:						
December 31, 2002.....	$ 2,257	$ 427,192	$ --	$ 14,446	$ 174,930	$ 14,4
December 31, 2001.....	2,236	385,705	--	14,327	186,296	15,4
December 31, 2000.....	2,015	374,554	--	13,493	203,075	15,0

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
SECTION 403.04.b
EXHIBIT OF REDUNDANCIES (DEFICIENCIES)
(In thousands)

	Year ended December 31,							
	2002	2001	2000	1999	1998	1997	1996	1
Losses and LAE Reserve.....	$427,192	$385,705	$374,554	$ 244,394	$212,264	$202,699	$187,776	$182
Less Reinsurance Recoverables (1).	169,001	187,453	218,757	110,089	37,797	21,056	15,676	25
Net Loss and LAE Reserves.....	258,191	198,252	155,797	134,305	174,467	181,643	172,100	156
Net Reserve Re-estimated as of:								

1 Year Later		222,250	164,488	157,598	184,386	172,000	163,130	141
2 Years Later ...			179,043	171,136	204,029	173,596	146,987	132
3 Years Later ...				183,524	218,626	186,794	140,563	113
4 Years Later ...					231,386	198,403	146,266	102
5 Years Later ...						210,763	153,423	104
6 Years Later ...							159,652	108
7 Years Later ...								111
8 Years Later ...								
9 Years Later ...								
10 Years Later...								
Cumulative Redundancy (Deficiency).....		(23,998)	(23,246)	(49,219)	(56,919)	(29,120)	12,448	45
Cumulative Net Paid as of:								
1 Year Later.....		74,125	69,599	61,522	80,416	71,933	56,977	45
2 Years Later....			105,043	103,855	124,191	117,794	91,765	70
3 Years Later....				127,505	159,335	143,369	113,054	83
4 Years Later....					179,825	164,584	125,024	91
5 Years Later....						178,482	135,421	95
6 Years Later....							142,508	100
7 Years Later....								103
8 Years Later....								
9 Years Later....								
10 Years Later...								
Net Reserve.....	258,190	198,252	155,797	134,305	174,467	181,643	172,100	156
Reins. Recoverables..	169,002	187,453	218,757	110,089	37,797	21,056	15,676	25
Gross Reserve	$427,192	385,705	374,554	244,394	212,264	202,699	187,776	182
Net Re-estimated Reserve		222,250	179,043	183,524	231,386	210,763	159,652	111
Re-estimated Reins Recoverables		216,060	279,973	179,794	75,589	32,849	24,877	20
Gross Re-estimated Reserve		438,310	459,016	363,318	306,975	243,612	184,529	131
Gross Cumulative Redundancy (Deficiency)...		$(52,605)	$(84,462)	$(118,924)	$(94,711)	$(40,913)	$ 3,247	$ 51

(1) Amounts reflect reinsurance recoverable under prospective reinsurance contracts only. Reinsurance recoverables on unpaid losses and LAE are shown as an asset on the balance sheets at December 31, 2002 and 2001. However, for purposes of the reconciliation and development tables, loss and LAE information are shown net of reinsurance.