SIERRA HEALTH SERVICES INC
Form 10-K
March 05, 2004

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, 2003

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. [X]

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 30, 2003 was $554,306,000.

The number of shares of the registrant's common stock outstanding on February 27, 2004 was 27,046,000.

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.
2003 Annual Report on Form 10-K

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PART I

ITEM 1. 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 health care organization that provides and administers the delivery of comprehensive health care programs with an emphasis on quality care and cost management. Our strategy has been to develop and offer a portfolio of managed health care products to employer groups and individuals. Our broad range of managed health care 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 (consisting of approximately 707,000 eligible individuals as of December 31, 2003, in Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia and Washington, D.C.);
- ancillary products and services that complement our managed health care product lines; and

- a third-party administrative services program for employer-funded health benefit plans and self-insured workers' compensation plans.

Required financial information by business segment is set forth in Note 19 of the Notes to the Consolidated Financial Statements. Unless otherwise indicated, information presented in this 2003 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

The primary types of health care coverage offered by our subsidiaries are HMO plans, HMO Point of Service, or POS, plans, and managed indemnity plans, which include a managed indemnity preferred provider organization, or PPO, option. As of December 31, 2003, we provided HMO products to approximately 292,000 members. We also provided managed indemnity products to approximately 25,000 members, Medicare supplement products to approximately 18,000 members, and administrative services to approximately 193,000 members. Medical premiums accounted for approximately 65% of total revenues from continuing operations in 2003.

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 independent contracted providers. We also operate a network model HMO in Reno, Nevada. Independent 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, 2003, we had approximately 202,000 commercial members. Based on data provided by the Nevada State Health Division as of September 30, 2003, we maintain approximately 62% of the Nevada, and approximately

76% of the Las Vegas, commercial HMO market share. In southern Nevada, HMOs have a market penetration of under 17%.

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, 2003, we had approximately 51,000 Medicare members of which approximately 49,000 were enrolled in the Social HMO, which is discussed below.

In addition, as of December 31, 2003, we had approximately 39,000 members enrolled in our 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 and we also receive a per case fee for each Medicaid eligible newborn delivery.

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 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 members. The additional benefits include, among other things, assisting the eligible Medicare members with activities of daily living such as bathing, dressing and walking. The members who receive these benefits, as identified by the health risk assessments, are those who currently have difficulty performing activities of daily living functions because of a health problem or physical disability.

Effective January 2004, CMS has revised the payment factors for Medicare members to include a risk adjustment methodology and a frailty adjuster that uses measures of functional impairment to predict expenditures. Under the new payment methodology, in 2004, we will be paid 90% based on the current payment approach and 10% based on the new approach. CMS has preliminarily indicated that the payment methodology will be completely transitioned to the new approach in 2008. The Social HMO program was due to expire at the end of 2003; however, CMS administratively extended the Social HMO program for one year, through 2004. Continuation of this program is under consideration, but there is no guarantee at this time that the Social HMO contract will be renewed beyond 2004. If the Social HMO contract is not renewed beyond 2004, we would seek to transfer the members into one of our traditional Medicare plans. This transfer would allow for the continuity of care for our members but without the additional Social HMO specific benefits that are currently available to them. 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 Medicare medical premium revenue growth is principally dependent upon continued enrollment in our products and upon competitive and regulatory factors.

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.

During 2003, 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, 2003, our managed indemnity subsidiary was licensed in a total of 44 states and the District of Columbia.

Ancillary Medical Services.

Most of our managed health care services in Clark County and surrounding rural areas are provided through our independent contracted network of approximately 2,300 providers and 28 hospitals. These Nevada networks include our affiliated multi-specialty medical group, which provides medical services to approximately 75% of our southern Nevada HMO members and employs approximately 200 primary care and other providers in various medical specialties. Through our affiliates the following services are offered: three urgent care centers; home health care; hospice care; behavioral

health care; home infusion; oxygen and durable medical equipment; a free-standing ambulatory surgery center; radiology; and occupational medicine.

These services are provided to members of our HMO, managed indemnity, fee-for-service and administrative service plans. As of December 31, 2003, mental health and substance abuse services were provided to approximately 212,000 participants.

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, 2003, approximately 193,000 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 health care coverage to dependents of active duty military personnel, military retirees and dependents of military retirees through subcontractor partnerships and individual providers in Region 1. SMHS also performs specific administrative services, including health care appointment scheduling, enrollment, network management and health care management services. SMHS performs these services using primarily DoD information systems.

SMHS completed the fifth year of a five-year contract in May 2003 and is in the first year of a contract extension. In August 2002, the DoD requested proposals for managed care services under the Next Generation TRICARE, or T-Nex, contract. We submitted our proposal in January 2003 for the T-Nex North Region contract, which includes Region 1, as well as Michigan, Ohio, Kentucky, Indiana, Illinois, Wisconsin, Virginia and North Carolina. However, in August 2003, the DoD awarded the T-Nex North Region contract to a competitor and the General Accounting Office denied our protest of the award in December 2003. The new contractor is scheduled to be operational in Region 1 on September 1, 2004 and the new contract will supersede the remainder of our current TRICARE Region 1 contract. After the new contractor is operational on September 1, 2004, SMHS will commence a six-month phase-out of operations at prices previously negotiated with the DoD. SMHS does not meet the definition of discontinued operations since we do not have plans to dispose of the operations before the phase-out is complete.

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 wrote 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 61%, 10%, and 20%, respectively, of CII's fully insured workers' compensation insurance premiums in 2003. CII generated total revenues of $132.3 million in 2003. 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 to dispose of CII. Sierra's Board of Directors approved the sale of the operations on December 31, 2002. Accordingly,

beginning in the fourth quarter of 2002, we reclassified our workers' compensation insurance business as discontinued operations.

In conjunction with the decision to sell the workers' compensation operations at the end of 2002, 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.

In the second quarter of 2003, we recorded $4.0 million, $2.6 million after tax, in additional valuation adjustments. On November 25, 2003, we announced that we had reached an agreement to sell California Indemnity Insurance Company, or Cal Indemnity, and its subsidiaries. Cal Indemnity is a wholly-owned subsidiary of CII and is CII's only significant asset. As part of the purchase agreement, Cal Indemnity and its subsidiaries have voluntarily stopped issuing new or renewal policies except in Nevada. The buyer intends to place Cal Indemnity and its subsidiaries in

run-off. An independent third party claims administrator has been engaged to administer the claims when the transaction is consummated. The transaction was initially valued at $79.5 million, consisting of $15.5 million payable at closing and a contingent payment of $64.0 million which will be payable in 2010. The cash payable at closing is subject to certain adjustments and the contingent payment can be increased or decreased based upon favorable or adverse loss and allocated loss adjustment expense development from closing through December 2009. We have currently estimated that the adjustments will reduce the net sales proceeds to approximately $73 million. In the fourth quarter of 2003, we recorded a charge of $15.6 million, gross and net of tax, to write down the investment in Cal Indemnity to its estimated net sales proceeds. We did not recognize a tax benefit on the charge since our tax basis was less than our investment in Cal Indemnity. The sale is subject to regulatory approvals and is expected to close by April 30, 2004.

Subsidiary Summary

The following briefly describes our significant subsidiaries:

Managed Care Operations:

Health Insurers:

- Health Plan of Nevada, Inc., or HPN, a Nevada corporation, is a federally qualified health maintenance organization or HMO.
- Sierra Health and Life Insurance Company, Inc., or SHL, a California corporation, provides managed indemnity plans, as well as Medicare Select products in six states.

Multi-specialty medical group and other ancillary services to support our managed care operations:

- Southwest Medical Associates, Inc., is Nevada's largest multi-specialty medical group serving as the primary care provider for almost 75% of our southern Nevada HMO members.
- Behavioral Healthcare Options, Inc., provides mental health and substance abuse services.
- Family Health Care Services is a full service home health agency licensed by the State of Nevada, providing in-home care and case management.
- Sierra Home Medical Products, Inc., provides home infusion care and home medical equipment and supplies.
- Family Home Hospice, Inc., is a Medicare/Medicaid certified agency that provides in-home hospice care and counseling for the terminally ill.

Other managed care operations:

- Sierra Health-Care Options, Inc., operates third-party administrative services programs for employer-funded health benefit plans.
- Nevada Administrators, Inc., operates as a third-party administrator of workers' compensation claims for self-insured Nevada employers.

Military Health Services Operations:

- Sierra Military Health Services, Inc., is a Delaware corporation which administers a managed care federal contract for the Department of Defense's TRICARE program in Region 1.

Discontinued Texas HMO Health Care Operations

- Sierra Health Holdings, Inc., a Nevada corporation, is the parent company for Texas Health Choice, L.C., part of our discontinued Texas HMO health care operations.

Discontinued Workers' Compensation Operations:

- CII Financial, Inc., a California corporation, is the parent company of our four workers' compensation insurance companies. CII Financial, Inc. and its subsidiaries represent the discontinued workers' compensation operations.

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 annual 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.

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,				
	2003	2002	2001	2000	1999
Continuing Operations:					
HMO:					
Commercial	202,000	187,000	175,000	140,000	149,000
Medicare	51,000	48,000	45,000	42,000	42,000
Medicaid	39,000	37,000	27,000	15,000	11,000
Managed Indemnity	25,000	27,000	29,000	31,000	37,000

Medicare Supplement	18,000	19,000	23,000	28,000	28,000
Administrative Services	193,000	221,000	196,000	197,000	222,000
TRICARE Eligibles	707,000	678,000	639,000	621,000	610,000
Total Membership, Continuing Operations	1,235,000	1,217,000	1,134,000	1,074,000	1,099,000
Discontinued Operations:					
HMO:					
Commercial	--	--	43,000	73,000	114,000
Medicare	--	--	12,000	8,000	11,000
Total Membership, Discontinued Operations	--	--	55,000	81,000	125,000

We categorize groups by size into small, mid-size and large. At December 31, 2003, the breakdown of our commercial membership by size and type are as follows:

Membership by Commercial Employer Group Size	
1 - 50 employees (small)	14.5%
51 - 500 employees (mid size)	23.1%
501 + employees (large)	62.4%
Total	100.0%

Membership by Commercial Employer Group	
Gaming	28,000
School Districts	23,000
Government	26,000
National Accounts	21,000
Unions	18,000
All Others	86,000
Total	202,000

During 2003, 2002 and 2001, we received approximately 25.3%, 26.6% and 27.6%, 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 and the loss of our Medicare revenue would have a material adverse effect on our business. In addition, there may be 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 generally 60 days prior notice. For the fiscal year ended December 31, 2003, 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. 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 75% of our southern Nevada HMO members receive primary health care through our own multi-specialty medical group. We make health care available through independent providers employed by the multi-specialty medical group and other independent 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 independent 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 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 rate increases for 2004 have been factored into our 2004 premiums. Our contract with Sunrise and Mountain View contains a clause, which, based on our meeting certain utilization requirements, requires Sunrise and Mountain View to provide us with their best rates in the market place. Since the 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 health care 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, discounted per diem, DRG and modified fee-for-service arrangements. To the extent feasible, 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 rate based on payments actually received by such providers from other third party payors.

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 37,000 individual providers, 2,700 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 pharmacies, non-network retail pharmacies or through the National Mail Order Pharmacy. SMHS does not assume any health care underwriting risk under this new program, which expires on June 1, 2004.

On October 1, 2001, SMHS implemented the TRICARE for Life program. This new DoD program provides continued TRICARE coverage to military family retirees age 65 and over, 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. Our current 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 purchased excess medical professional liability and managed care coverage that requires us to be responsible for a self insured retention of $3 million per loss event. In the case of a medical professional liability loss event, the $1 million primary policy limit will apply toward the $3 million self insured retention. The primary and excess medical professional liability policies apply retroactively to June 15, 2001. In addition, we require all of our independent 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 provided 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, have reduced coverage limits and exclusions for terrorist acts. We continue to retain the first $500,000 per occurrence but the maximum coverage has been reduced from statutory limits (i.e., unlimited) 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 the A.M. Best Company as of December 31, 2003.

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 2003, we completed the construction of a third data center supporting our Las Vegas-based operations to provide internal options for disaster recovery and back up. We completed the rollout of an e-prescribing application in our medical clinics as well as a system to capture and view radiology images electronically. Dictation and transcription systems were replaced and we began the migration to a paperless electronic medical record system. A new care

management system was implemented to support the coordination of care for seniors enrolled in our Social HMO program. Compliance with the Federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, was achieved as required by the Privacy Rule and the Standards for Code Sets and Electronic Transactions. Work was also initiated to achieve compliance with the HIPAA Security Rule, which must be addressed by April 20, 2005. Other security and controls work was initiated in 2003 toward compliance with Section 404 of the Sarbanes-Oxley Act of 2002.

There can be no assurance that we will be able to maintain and enhance our information systems including HIPAA and Sarbanes-Oxley 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. The National Committee for Quality Assurance, or NCQA, and the Utilization Review Accreditation Commission, or URAC, currently evaluate certain of our subsidiaries.

The NCQA is an independent, not-for-profit organization that evaluates managed care organizations and assesses and reports on the quality of managed care plans by evaluating over 60 standards that fall into four categories: (i) quality management and improvement; (ii) utilization management; (iii) members' rights and responsibilities; and (iv) credentialing and recredentialling. The NCQA's accreditation levels include excellent, commendable, accredited, provisional and denied. In 2003, we earned a "Commendable" status from the NCQA for our commercial HMO, commercial POS, and Medicare HMO product lines. "Commendable" status is awarded to plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

URAC's Health Utilization Management Standards, or UM standards, program is the largest and most recognized program of its type in the United States. The UM standards are meant to ensure organizations follow a process that is clinically sound, promotes quality care and respects members' rights. URAC performs reviews of standards in the following categories: confidentiality, staff qualifications, program qualifications, information upon which organizations conduct utilization management, procedures for review determination and procedures for appeals of determinations not to certify (expedited and standard appeals). The URAC accreditation levels include full, conditional, corrective action, denied, or withdrawn. Applicants who successfully meet all requirements are awarded a full two-year accreditation. In 2003, our HPN, SHL, Sierra Health-Care Options, Inc., and Behavioral Healthcare Options, Inc., utilization management operations were all "Fully Accredited" by URAC, under URAC's UM standards program.

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

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.

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. 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.

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 health and life insurance subsidiaries are as follows:

- A.M. Best Company, Inc., "B+" (Very Good, 6 th of 16); and
- Fitch Ratings, "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 Ratings, "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. A qualified actuary as determined by the applicable state insurance regulators must sign the actuarial opinion. 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 2003 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, appeals, external review of adverse benefit determinations, 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. Federal legislation enacted in December 2003 (Medicare Prescription Drug, Improvement, and Modernization Act of 2003), while generally favorable to our business, may result in increased competition for Medicare beneficiaries and, thus, may have a material adverse effect on our business and results of operations.

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 effect our business and results of operations.

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 December 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA, which, among other changes to Medicare, alters the Medicare+Choice program. Under the MMA, Medicare+Choice plans, which are renamed Medicare Advantage plans, receive increased funding from CMS starting March 2004. Because of the way in which the increased funding is calculated, both our non-Social HMO Medicare Advantage benefit plans and our Social HMO benefit plans will receive increased funding. We have calculated that the MMA will increase our Medicare premium rates by over 15% starting March 1, 2004. The increased funding must be used in one or more of the following ways: to reduce beneficiary premiums; reduce beneficiary cost sharing; enhance benefits; placed into a benefit stabilization fund; or used to retain providers or expand the provider network as long as the provider network stabilization or enhancement does not result in increased premiums, increased cost sharing or reduced benefits. In response to the announcement of the specific increased funding amount, we recently filed our Adjusted Community Rate Proposal, or ACRP, with CMS. We proposed to use the additional funding to enhance various plan benefits, including a reduction in the amount of Medicare Part B premium that our members pay to the federal government, and to stabilize the provider network. In late February 2004, we received approval of our ACRP from CMS.

The MMA expands the options that will be available to Medicare beneficiaries for their health care coverage, including regional Preferred Provider Organizations. Beginning with the 2006 contract year, the payment methodology will change from the current government price-setting to market-place competition, whereby private health plans will compete for beneficiaries through a competitive bidding process.

The MMA establishes a Medicare Part D program which, when it becomes effective January 1, 2006, will provide beneficiaries under the traditional fee-for-service Medicare program with coverage for outpatient prescription drugs, a benefit the beneficiaries don't currently have. Although varying in structure, we have to date, included coverage for prescription drugs in our benefit plans.

Prior to the implementation of Medicare Part D in 2006, the MMA provides for an interim prescription drug discount card program. This program is expected to be operational in Spring 2004. Known as the Medicare Prescription Drug Discount Card and Transitional Assistance Program, this program is designed to provide savings for beneficiaries through discounts at retail or through mail order pharmacies, depending upon the benefit design, until the Medicare Part D program goes into effect. Low-income beneficiaries will be eligible for federal subsidies to help pay for their prescription drugs under this interim program. We have submitted applications to CMS to participate in this program as Medicare-endorsed sponsors. One application is to participate with a discount card exclusive to our Medicare plan members and another for marketing to other Medicare beneficiaries.

The MMA also allows for the implementation of Health Savings Accounts, or HSAs, beginning January 1, 2004. Not generally available to Medicare beneficiaries, HSAs are designed for individuals with high-deductible health plans. Contributions to the HSAs are permitted up to the applicable plan deductible, with caps at specific amounts, and are used to pay for qualified medical expenses. In addition to allowing for HSA balances to accumulate from year-to-year, HSAs have tax advantages to employers who contribute on their employees' behalf and to individuals who contribute themselves.

The legislation also further delayed the "lock-in" requirement until 2006. Once fully implemented, "lock-in" will restrict a Medicare beneficiary's ability to change his or her health care coverage on a monthly basis as is currently allowed; e.g., from traditional fee-for-service Medicare to a Medicare Advantage program and back again on a monthly basis. The "lock-in" requirement could slow the growth rate of our Medicare Advantage membership as potential members would have fewer opportunities to select our plan.

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 Nevada HMO is federally qualified under the Federal HMO Act and is subject to this 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 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 44 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. Section 1320a-7b(b) (the Anti-kickback Statute) and Section 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. The U.S. Department of Health and Human Services, or 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 actions we take, 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 continuation of the Social HMO program through legislative action and/or or a CMS administrative remedy. 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 2004. Substantially all of our Medicare members are enrolled in the Social HMO program and the discontinuation of the program would adversely affect our business and results of operations.

HIPAA contains provisions that impact us and will require operational changes as various federal departmental regulations required by the Act are promulgated. During 2003, two major milestones were achieved. First, we established the policies and ongoing procedures to comply with the health information privacy rule by the compliance date of April 14, 2003. Complying with the HIPAA privacy rule requires ongoing diligence to ensure that appropriate measures are being taken to maintain the privacy of protected health information. We have the management processes in place to ensure our ongoing compliance with the HIPAA privacy rule. Second, we completed the development of the information systems capabilities necessary to support the HIPAA requirements for the use of standard code sets and transactions for specific electronic health care transactions. To date, we have implemented claims and enrollment standard transactions with a number of trading partners (e.g., providers, clearinghouses and employers). Relative to the other HIPAA defined transactions, none of our trading partners have developed the capability to handle these transactions with us. Ongoing compliance with the HIPAA privacy rule and transaction standards will be managed by the Department of Health and Human Services through a complaint process. There can be no assurance that a complaint will not be filed against us or whether there would be any material impact on our business to resolve the complaint.

A third HIPAA mandated regulatory rule addressing security requirements for covered entities has been established and work is underway to meet the requirements of this new rule. The compliance date for the HIPAA security rule is April 20, 2005. 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 2003, Congress passed Do Not Call List legislation and the Federal Trade Commission and the Federal Communications Commission adopted implementing regulations. We believe we are in compliance with the current legislation and regulations and the cost of compliance has been minimal.

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 delegates to the regulatory agencies broad regulatory, supervisory and administrative authority. Typically, state regulations extend to matters such as licensing insurers, agents and claims adjusters and regulating their relationships; restricting the types and quality of an insurer's investments; requiring financial and market conduct examinations of insurers at regular intervals; regulating premium rates, forms, use of some underwriting criteria and advertising; limiting the grounds and requiring notices for cancellation or nonrenewal of policies; prohibiting certain solicitation and replacement practices; and specifying what might constitute unfair practices.

Typically, states mandate participation in insurance guaranty associations, which assess solvent insurers in order to fund claims of policyholders of insolvent insurers. 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, insurers 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.

Starting in 2000, the California Insurance Guarantee Association, or CIGA, issued assessments as a result of the insolvency of a number of insolvent workers' compensation insurers. The assessments are initially made on direct premiums written, as reported in the prior year, and are subsequently adjusted to actual direct premiums written in the following year. For example, CIGA issued an assessment of 1% in 2000 using 1999 direct premiums written as the initial assessment. We began recouping the 1% assessment from policyholders on policies issued effective January 1, 2001. Our initial assessment was adjusted during 2002 to our actual premiums written during 2001. Any difference between the actual and initial premium assessment is either refunded to us, in the case of lower actual premiums, or we may have to pay additional assessments if actual premiums are higher. Moreover, any excess assessments that we recoup must be paid to CIGA. The CIGA assessment was increased to 2% effective January 1, 2002 and CIGA has continued to assess 2% during 2003 and 2004. It is likely that guarantee fund assessments related to insolvent workers' compensation insurance companies will continue for the next several years.

At December 31, 2003, we had receivables of $3.8 million relating to CIGA assessments, which are included in the assets of discontinued operations. Assessments by non-California states, which are expensed as incurred, totaled $350,000 during 2001, $580,000 during 2002 and $430,000 during 2003.

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 $36.5 million at December 31, 2003. 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 of $1.5 million 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 company subsidiaries are restricted by state law as to the amount of dividends or distributions that can be declared and paid. Moreover, insurers 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 insurers 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, Cal Indemnity 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, Cal Indemnity paid dividends of $1.5 million. No dividends were paid in 2003. 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 what will be the effect of any such proposals or restrictions on them.

Employees

We had approximately 3,600 employees as of March 1, 2004. 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 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.

We also make available on our website our Corporate Governance Guidelines, Code of Ethics for Directors, Code of Ethics, Code of Conduct for CEO, Nominating and Governance Committee Charter, Compensation Committee Charter and Audit Committee Charter. Such information is also available in print free of charge to stockholders upon request.

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 potential issues that could cause our actual results to differ substantially from our expectations are:

- loss of health care premium revenues due to heightened pricing competition;
- inadequate premium revenues due to heightened competition, miscalculations of underlying health care 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 health care benefits to offset the impact of inadequate premium rates;
- loss of Medicare or Medicaid contracts;
- increased charges and losses from the disposition of our workers' compensation insurance business or the inability to complete the disposal of such business at all or on acceptable terms;
- loss of or significant changes in our health care provider contracts;
- inability or unwillingness of our contracted providers to provide health care 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 health care claims and health care 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;

- a sustained economic recession, especially in Nevada;
- adverse loss development on health care 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 health care quality rating organizations, such as the NCQA or URAC;
- changes in federal or state tax regulations and laws or programs, including health care 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 Part 1, Item 1 of this 2003 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 adversely affected. 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 adversely affect our business as well.

Risks Related to our Continuing Operations

The termination of the TRICARE Region 1 contract, expected on September 1, 2004, will materially adversely affect our revenues and operating income for future years.

On August 21, 2003, we were advised that the T-Nex contract for the North Region had been awarded to one of our competitors. After health care service begins under the T-Nex contract, which we currently expect to start September 1, 2004, we will only receive "phase-out" revenues under our current TRICARE Region 1 contract. These "phase-out" revenues will be significantly less than the revenues SMHS earned under the TRICARE Region 1 contract. For the year ended December 31, 2003, our Military Health Services Operations segment accounted for $467.3 million, or 31.5%, of total consolidated revenues and $14.8 million, or 11.2%, of total consolidated operating income from continuing operations. In addition, while the TRICARE Region 1 contract provides for the payment of certain "phase-out" costs that we may incur, there can be no assurance that this payment will cover all such costs. As a result,

our failure to win the competitive procurement for the T- Nex contract will have a material adverse effect on our revenues and operating income for future years.

The new Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, may intensify the competition in Nevada for the eligible senior population and could lead to a loss of our senior members and a reduction in Medicare premium revenues. If we are unable to reduce our costs timely, our operating margins may be adversely affected.

The MMA will substantially increase the amount of Medicare premiums paid to health plans. However, all of the increased revenues must either be used to enhance benefits, reduce the members' costs or stabilize network providers. MMA could bring new competitors into Nevada. These new competitors, as well as existing competitors, may offer better benefits or lower costs to our senior members, which may result in a loss of members and Medicare revenues. It could also lead to our retaining a less healthy mix of members who incur more medical costs. If we are unable to timely reduce our operating costs, our operating margins may be adversely affected.

The payment methodology for our Social HMO Medicare program is expected to result in a lower premium rate increase. In addition, there is no guarantee that the Social HMO program will be extended beyond 2004. If we were unable to compensate by reducing costs, our financial results would be materially affected.

Our Medicare program accounted for approximately 25% of our 2003 consolidated revenues from continuing operations. Starting in 2004, CMS has changed the Medicare payment methodology to include a risk adjustment methodology and a frailty adjuster that uses measures of functional impairment to predict expenditures. Under the new payment methodology, we will be paid 90% based on the current payment approach and 10% based on the new approach. The new payment approach is being phased in and CMS has preliminarily indicated that it will be completely transitioned to the new approach in 2008. Based on the most recent information available to us, our 2004 annual Medicare increase, before the effect of the new payment approach and the MMA, would have been 3.1%. The new payment approach reduced this to 2.5%.

Every year, we receive adjustments to the amount CMS pays us for the services we provide to our Medicare enrollees and we adjust the benefits we provide to Medicare enrollees to reflect the changing CMS payments so that we can maintain our operating margin. In addition, the Social HMO program was due to expire at the end of 2003; however, CMS administratively extended the Social HMO program for one year. There are activities taking place on a federal level to continue the program, but there is no guarantee at this time that the Social HMO contract will be renewed beyond 2004. If the Social HMO contract is not renewed beyond 2004, we would seek to transfer the members into one of our traditional Medicare plans. This transfer would allow for the continuity of care for our members but without the additional Social HMO specific benefits that are currently available to them. If we are unable to adjust benefits we provide to Medicare enrollees to reflect changes in CMS payments and in costs of providing benefits so that we can continue to maintain our operating margin, or if our contract with CMS were to be terminated, our financial results would be materially adversely impacted.

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

We and our health care providers are subject to malpractice claims. We require our health care 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.

If we fail to qualify for the Nevada home office tax credit, our premium 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 substantially increase our premium tax burden and, as a result, materially adversely affect our profitability.

Our ability to obtain and maintain favorable group benefit agreements with employer groups affects our profitability.

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, 2003, 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 our 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.

There can be no assurance that we will be able to maintain and enhance our information systems.

Our information systems are a vital and integral part of our operations. We depend on our information systems to enable us to bill and collect premium revenues, process and pay claims and other operating expenses, and provide effective and efficient services to our customers. We also depend on our information systems to provide us with accurate and complete data to enable us to adequately price our

products and services and report our financial results. We are required to commit significant ongoing resources to maintain and enhance our existing information systems as well as develop new systems to keep pace with continuing changes in technologies, industry practices, regulatory standards and changing customer preferences.

For example, the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 or HIPAA and the Department of Labor's ERISA claim processing regulations require changes to our current systems. In 2003, we completed construction of a third data center supporting our Las Vegas-based operations to provide internal options for disaster recovery and back up. We completed the rollout of an e-prescribing application in our medical clinics as well as a system to capture and view radiology images electronically. Dictation and transcription systems were replaced and we began the migration to a paperless electronic medical record system. A new care management system was implemented to support the coordination of care for seniors enrolled in our Social HMO program. Compliance with the Federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, was achieved as required by the Privacy Rule and the Standards for Code Sets and Electronic Transactions. Work was also initiated to achieve compliance with the HIPAA Security Rule, which must be addressed by April 20, 2005. Other security and controls work was initiated in 2003 toward compliance with Section 404 of the Sarbanes-Oxley Act of 2002.

If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could lose existing customers, have difficulty in attracting new customers, have problems in determining medical cost estimates and establishing appropriate pricing, have

customer and physician and other health care provider disputes, have regulatory problems, have increases in operating expenses or suffer other adverse consequences.

We operate in a highly competitive environment.

We operate in a highly competitive environment. Our major competition is from self-funded employer plans, PPO products, 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. It is impractical to attempt to quantify the financial impact of an unspecified reduction in membership. However, we believe any reductions in our membership levels that are not compensated by reductions in operating expenses could materially affect 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 health care 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 in future periods as required. These estimates could understate or overstate our actual liability for claims and benefits payable. For example, during 2003, our actuarial best estimate of the liability recorded as of December 31, 2002 decreased approximately $14.0 million. This is compared to a decrease of $10.9 million in the liability recorded as of December 31, 2001 during 2002. Any increases to prior estimates could adversely affect results of operations in future periods. In addition, the premium pricing of our health care plans take into consideration past historical cost trends. If our actual liability for claims and benefits are higher than our prior recorded estimates, our business and results of operations in future periods could be adversely impacted.

Our failure to comply with "corporate practice of medicine" laws in states in which we operate could result in our being unable to practice medicine in that state and possibly lead to penalties and/or higher medical expenses.

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 in compliance with these laws in all states. A determination that our medical provider subsidiary, Southwest Medical Associates Inc. or SMA is not exempt and is not in compliance with applicable corporate practice of medicine laws in Nevada could result in SMA being unable to practice medicine in Nevada and possibly lead to penalties and/or higher medical expenses.

Approximately 75% of our southern Nevada HMO health care members choose one of our SMA physicians as their primary provider. A determination that SMA is not in compliance with applicable corporate practice of medicine laws in Nevada could require that we divest our ownership interest in or dissolve SMA. Alternatively, we may be required to expand our network of independent contracted providers, all of which could lead to a disruption in our provider

network, member dissatisfaction and ultimately higher medical expenses for our HMO and health care insurance subsidiaries.

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 aggregate principal amount of 2¼% senior convertible debentures due March 15, 2023. The debentures pay interest, which is due semi-annually on March 15 and September 15 of each year. Each $1,000 principal amount of debentures is convertible, at the option of the holders, into 54.6747 shares of Sierra Health Services, Inc., common stock prior to March 15, 2023 if (i) the market price of our common stock for at least 20 trading days in a period of 30 consecutive trading days ending on the last trading day of the preceding fiscal quarter exceeds 120% of the conversion price per share of our common stock; (ii) the debentures are called for redemption; (iii) there is an event of default with respect to the debentures; or (iv) specified corporate transactions have occurred. The conversion rate is subject to certain adjustments. This conversion rate initially represents a conversion price of $18.29 per share. Holders of the debentures may require us to repurchase all or a portion of their debentures on March 15 in 2008, 2013 and 2018 or upon certain corporate events including a change in control. In either case, we may choose to pay the purchase price of such debentures in cash or common stock or a combination of cash and common stock. 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 debt levels may limit our flexibility in obtaining additional financing and in pursuing other business opportunities.

As of December 31, 2003 we had approximately $117.0 million of indebtedness on a consolidated basis. This level of indebtedness will have several important effects on our future operations, including our ability to obtain additional financing for working capital, capital expenditures, acquisitions, general corporate and other purposes.

Our ability to meet our debt service obligations and to reduce our total indebtedness depends upon our future performance, which will be subject to general economic conditions, industry cycles and financial, business and other factors affecting our operations, many of which are beyond our control.

Our senior secured credit facility imposes significant operating and financial restrictions on us.

We entered into a revolving credit facility on March 3, 2003 and as of December 31, 2003, we have not borrowed on it. The 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) other than cash and cash equivalents, subject, in each case, to the exclusion of the capital stock of CII or any of its subsidiaries and certain other exclusions.

The revolving credit facility restricts 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 are required to comply with specified financial ratios as set forth in the credit agreement. A failure to comply with these covenants

would be an event of default under the credit agreement. The revolving credit facility matures on April 30, 2006. There is no assurance that we will be able to successfully refinance or pay any outstanding indebtedness 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 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 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 health care 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 could 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 health care costs and the inability of many individuals to obtain health care insurance, numerous proposals relating to health care reform have been or 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 health care 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 regulates Medicare and Medicaid programs; federal and state fraud and abuse laws; and laws relating to utilization management and the delivery of health care 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 may not realize the total amount of the estimated net sales proceeds from our pending sale of the workers' compensation insurance operations.

In the fourth quarter of 2003, we agreed to sell our workers' compensation insurance subsidiaries, consisting of California Indemnity Insurance Company and its wholly-owned insurance subsidiaries, and we reduced the investment in these operations to their estimated net sales proceeds. The closing of the sale is currently pending regulatory approval, which is expected by April 30, 2004. The majority of the net sales proceeds will be payable in 2010 and is subject to adjustment based upon the loss and allocated loss adjustment expense development from the closing date through December 31, 2009. Factors such as reinsurers failing to honor their obligations to the workers' compensation subsidiaries, economic recessions and the resulting higher unemployment rates, over utilization of medical treatments, and the effect of new legislation or regulations could affect the subsidiaries' loss and allocated loss adjustment expense development. The net sales proceeds will be reduced after closing, up to a maximum of $58 million, by the amount of net adverse loss development. The net sales proceeds will increase dollar for dollar on the first $15.0 million of net favorable loss development and 50% of any favorable development above that $15.0 million. While we believe the recorded loss and loss adjustment expense reserves are appropriately stated on our balance sheets, we have had net adverse loss development occur in each of the past five years. For the years ended December 31, 2001, 2002 and 2003, we recorded net adverse loss development of $8.7 million, $24.0 million and $16.9 million related to prior periods, respectively. In addition, effective with the close of the sale, the workers' compensation claims will be out-sourced to an independent third party claims administrator or TPA. Part of the TPA's compensation is subject to satisfactory adherence to certain agreed upon claims administration processes and procedures. While we will audit the claims handling performance of the TPA, we cannot be certain that all of the claims will be administered in the most cost effective manner, which could result in adverse loss development. There is no assurance that we will actually realize the estimated net sales proceeds and any adjustments after the close of the sale will affect the results of continuing operations in the year the adjustment occurs. In addition, insurance regulators may impose significant restrictions on the buyer, which may allow the buyer to cancel the stock purchase agreement.

We will be obligated to perform certain services in connection with the sale of the workers' compensation insurance operations and the accrual for the estimated contractual funding shortfall may be insufficient, which could result in a material adverse effect to our financial results.

The sale of the workers' compensation insurance operations will require us to perform, or be responsible for the performance of, certain transition services through December 31, 2009. This includes claims administration, processing policy transactions, premium collections and other services related to insurance operations. We will receive a limited amount of funds to perform these services from Cal Indemnity and these funds may be insufficient to cover all of our costs. In addition, due to the discontinued status of the workers' compensation insurance operations,

we may experience significant employee turnover in this segment, which could result in unanticipated higher costs for temporary staff and/or retention incentive payments. If the contractual funding shortfall is understated, our financial results could be materially adversely affected.

If we are unable to complete the sale of our workers' compensation subsidiaries, there could be various adverse effects on our operating results and business.

Since executing the agreement in November 2003 to sell our workers' compensation insurance subsidiaries, we have taken various steps, required by the agreement, to cause those subsidiaries to cease writing new and renewal business, terminate agents as well as to terminate, or not enter into, various leases and other contracts that were necessary to the conduct of the worker's compensation insurance business. In addition, we have taken steps to reduce staff and have lost staff due to voluntary terminations. If, for any reason, we do not complete the sale of that business to the buyer, we will have lost the employees and closed the facilities necessary to operate the business and will have also terminated relationships with our workers' compensation insurance customers. We will then have few options other than to liquidate the business, which may result in further losses. In addition, the failure to complete that sale, or another sale, may result in our again consolidating the operating results of the worker's compensation business in our financial statements, resulting in significant changes to our earnings from continuing operations for prior and subsequent years.

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

ITEM 2. 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 347,000 and 389,000 square feet, respectively, with the majority of the lease agreements running through January, 2016. 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.

The workers' compensation subsidiary is headquartered in Nevada and subleases space from us as well as approximately 37,000 square feet of additional leased office space in California and Colorado with some lease agreements running through 2008. Sierra will be required to assume all outstanding lease agreements upon the sale of Cal Indemnity.

We lease approximately 162,000 square feet of office space in other various states as needed for the SMHS administrative headquarters, TRICARE service centers and other regional operations with some lease agreements running through 2012. We are attempting to sublease certain space we have already vacated and we will attempt to sublease any remaining space that will be vacant at the completion of the phase-out period.

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 and other 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 amount or range of any potential loss cannot be reasonably estimated but 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 2003 and 2002.

Period	High	Low
2003		
First Quarter	$ 14.75	$ 11.75
Second Quarter	21.67	12.24
Third Quarter	27.09	19.15
Fourth Quarter	29.42	21.25
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

On March 1, 2004, the closing market price of Common Stock was $34.60 per share.

Holders

The number of record holders of Common Stock at February 27, 2004 was 585. Based upon information available to us, we believe there are approximately 6,500 beneficial holders of the Common Stock.

Equity Compensation Plan Information

The following table provides information as of December 31, 2003, 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 se remaining av for future under eq compensation
	(In thousands, except exercise price)		
Equity compensation plans approved by security holders	1,634	$ 7.87	
Equity compensation plans not approved by security holders (4)	3,919	9.77	
Total	5,553	9.21	

See Note 16 of the Notes to the Consolidated Financial Statements for additional information on our stock based compensation plans.

(1) In addition, a total of 50,000 shares of common stock are subject to options assumed by the Company in connection with acquisitions, with a weighted average exercise price of $11.33.

(2) All of the shares available for future issuance include: (i) 1,773,000 shares under the 1995 Long-Term Incentive Plan, as amended and restated, issuable as restricted stock or as a bonus; (ii) 248,000 shares under the 1995 Non-Employee Directors' Stock Plan, as amended and restated, issuable in lieu of directors fees; and (iii) 191,000 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, warrant and rights.

(3) Includes 191,000 shares remaining available for future issuance under the ESPP of which 119,000 were issued in January 2004.

(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 3,734,000 shares in column (a)

and 1,151,000 shares in column (c) at December 31, 2002. The Compensation Committee of the Board of Directors, which is permitted to delegate authority in limited circumstances, administers the Plan. 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. The Committee sets vesting and forfeiture terms of awards. To date, the Company has granted primarily options and 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 185,000 shares in column (a) and 245,000 shares in column (c) at December 31, 2003. The Plan is administered by the Board of Directors. It authorizes the automatic grant of an option to purchase 10,000 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 78th 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 intend to retain our earnings for use in our business and to purchase our common stock and currently do not anticipate paying any cash dividends. 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 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 2003 Form 10-K. The selected consolidated financial data below has been derived from our audited Consolidated Financial Statements.

	Years Ended December 31,			
	2003	2002	2001	2000
	(In thousands, except per share d			
Statements of Operations Data:				
OPERATING REVENUES:				
Medical Premiums	$ 962,176	$ 857,741	$ 718,994	$ 637,7
Military Contract Revenues	465,313	373,589	338,918	330,3
Professional Fees	37,367	30,923	28,985	33,1
Investment and Other Revenues	20,223	16,382	16,603	18,3
Total	1,485,079	1,278,635	1,103,500	1,019,6
OPERATING EXPENSES:				
Medical Expenses	762,865	712,290	608,757	576,7
Military Contract Expenses	452,554	360,375	331,621	323,2
General and Administrative Expenses	137,263	133,979	122,623	112,2
Asset Impairment, Restructuring, Reorganization and Other Costs (1)	--	--	--	30,8
Total	1,352,682	1,206,644	1,063,001	1,043,0
OPERATING INCOME (LOSS) FROM CONTINUING OPERATIONS	132,397	71,991	40,499	(23,4
Interest Expense	(5,491)	(7,650)	(15,738)	(17,8
Other Income (Expense), Net	(223)	55	(2,119)	1,0
INCOME (LOSS) FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	126,683	64,396	22,642	(40,2
(PROVISION) BENEFIT FOR INCOME TAXES	(44,565)	(22,088)	(7,161)	9,2
INCOME (LOSS) FROM CONTINUING OPERATIONS	82,118	42,308	15,481	(31,0
LOSS FROM DISCONTINUED OPERATIONS	(19,792)	(5,860)	(11,995)	(168,8
NET INCOME (LOSS)	$ 62,326	$ 36,448	$ 3,486	$ (199,9
EARNINGS PER COMMON SHARE:				
Income (Loss) From Continuing Operations	$ 2.93	$ 1.47	$ 0.56	$ (1.
Loss from Discontinued Operations	(0.71)	(0.20)	(0.43)	(6.
Net Income (Loss)	$ 2.22	$ 1.27	$ 0.13	$ (7.
Weighted Average Number of Common Shares Outstanding	28,053	28,756	27,685	27,1
EARNINGS PER COMMON SHARE ASSUMING DILUTION:				
Income (Loss) From Continuing Operations	$ 2.70	$ 1.36	$ 0.54	$ (1.
Loss from Discontinued Operations	(0.65)	(0.19)	(0.42)	(6.

Net Income (Loss)	$ 2.05	$ 1.17	$ 0.12	$ (7.
Weighted Average Number of Common Shares Outstanding Assuming Dilution	30,421	31,141	28,509	27,1

	December 31,			
	2003	2002	2001	2000
	(In thousands)			
Balance Sheet Data:				
Working Capital	$ 171,652	$ 122,252	$ 65,986	$ 46,2
Total Assets	1,134,121	1,065,966	1,064,846	1,162,7
Long-term Debt (Net of Current Portion)	116,645	60,710	163,993	224,9
Cash Dividends Per Common Share	none	none	none	no
Stockholders' Equity	150,764	156,565	96,519	90,4

(1) We recorded certain identifiable asset impairment, restructuring, reorganization and other costs.

Ratio of Earnings to Fixed Charges

The ratio of earnings to fixed charges for the periods shown has been computed by dividing earnings available for fixed charges (income from continuing operations before income taxes plus fixed charges including capitalized interest) by fixed charges (interest expense including capitalized interest). Interest expense includes the portion of operating rental expense which we believe is representative of the interest component of rental expense.

	Years Ended December 31,			
	2003	2002	2001	2000
	(In thousands, except ratio data)			
Income (Loss) from Continuing Operations Before Income Taxes	$ 126,683	$ 64,396	$ 22,642	$ (40,224)
Fixed Charges:				
Interest expense (including capitalized interest)	5,506	7,700	15,767	17,932
Interest relating to rental expense (1)	6,795	5,205	2,609	2,387
Total fixed charges	12,301	12,905	18,376	20,319
Earnings available for fixed charges	$ 138,984	$ 77,301	$ 41,018	$ (19,905)
Ratio of earnings to fixed charges (2)	11.30	5.99	2.23	-

(1)The representative interest portion of rental expense was deemed to be one-third of all rental expense.
(2) Earnings were not sufficient to cover fixed charges during the year ended December 31, 2000 by $40.2 million; all other periods had sufficient income to cover fixed charges.

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

The following discussion and analysis provides information 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 Part 1, Item 1 of this 2003 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, or HMO, managed indemnity plans and military health care services. To a lesser extent, we also derive revenues from professional fees (consisting primarily of fees for providing health care services to non-members, co-payment fees received from members and ancillary products), and investment and other revenue (consisting of fees for workers' compensation third party administration, utilization management services and ancillary products).

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 independent 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 physician 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.

Executive Summary

Continuing Operations

. Our 2003 operating results were significantly improved over 2002. Our fully diluted income from continuing operations per common share increased by 98.5% to $2.70 and our income from continuing operations increased by 94.1% to $82.1 million. The improvement in the 2003 operating results was primarily driven by medical premium revenue growth from new members, rate increases and an expansion of our operating margin. Our HMO membership increased by 7.4% from 272,000 at December 31, 2002 to 292,000 at December 31, 2003. Our overall 2003 premium rates increased by approximately 7.6% over 2002. The combination of these factors resulted in a 12.2% increase in our medical premium revenues to $962.2 million. Our medical expenses, on the other hand, only increased by 7.1% to $762.9 million. Medical expenses, as a percentage of medical premiums and professional fees, decreased to 76.3% from 80.2%, or 390 basis points. In addition, our general and administrative expenses only increased by 2.5% to $137.3 million. As a percentage of total revenues, our general and administration expense ratio was reduced by 130 basis points to 9.2%. Our operating margin, which is the operating income from continuing operations divided by total revenues, improved by 330 basis points to 8.9%.

Our Military Health Services Operations segment represented 31.5% of our 2003 operating revenues and 11.2% of our 2003 operating income from continuing operations. This segment had income before income taxes of $14.9 million in 2003 compared to $15.5 million in 2002. However, if we exclude the T-Nex related expenses, the Military Health Services Operations segment would have had income before income taxes of $24.3 million in 2003 compared to $20.5 million in 2002. The improvement was due to greater administrative operating expense efficiencies. We did not win the T-Nex North Region contract and our appeal to the United States General Accounting Office was denied in December 2003. Health care services under our current TRICARE contract for Region 1 will end on August 31, 2004 and we will then have a six-month phase-out at substantially reduced revenues and earnings.

Our cash flows from operating activities of continuing operations increased by 11.1% to $151.9 million and were mainly attributable to the increase in net income. In March 2003, we issued $115.0 million aggregate principal amount of 2¼% senior convertible debentures due March 15, 2023, paid off our old credit facility balance and obtained a new $65 million revolving credit facility, which we have not yet utilized. The senior convertible debentures can be converted into 6.3 million shares of our common stock at a price of $18.29 per share. To help compensate for the potential dilution of the senior convertible debentures, we purchased, as of December 31, 2003, at prevailing prices in the open market by block purchase or private transactions, 5.3 million shares at an average cost of $18.66 per share. In January 2004, we obtained an amendment to our credit facility to allow for up to $60 million of additional purchases of our common stock and as of March 1, 2004, we have purchased an additional 708,000 shares for $22.6 million.

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 2001. 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 to dispose of CII. Sierra's Board of Directors approved the sale of the operations on December 31, 2002. Accordingly, beginning in the fourth quarter of 2002, we reclassified our workers' compensation insurance business as discontinued operations.

In conjunction with the decision to sell the workers' compensation operations at the end of 2002, 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.

In the second quarter of 2003, we recorded $4.0 million, $2.6 million after tax, in additional valuation adjustments. On November 25, 2003, we announced that we had reached an agreement to sell California Indemnity Insurance Company, or Cal Indemnity, and its subsidiaries. Cal Indemnity is a wholly-owned subsidiary of CII and is CII's only significant asset. As part of the purchase agreement, Cal Indemnity and its subsidiaries have stopped issuing new or renewal policies except in Nevada. The buyer intends to

place Cal Indemnity and its subsidiaries in run-off. An independent third party claims administrator has been engaged to administer the claims when the transaction is consummated. The transaction was initially valued at $79.5 million, consisting of $15.5 million payable at closing and a contingent payment of $64.0 million which will be payable in 2010. The cash payable at closing is subject to certain adjustments and the contingent payment can be increased or decreased based upon favorable or adverse loss and allocated loss adjustment expense development from closing through December 2009. We have currently estimated that the adjustments will reduce the net sales proceeds to approximately $73 million. In the fourth quarter of 2003, we recorded a charge of $15.6 million, gross and net of tax, to write down the investment in Cal Indemnity to its estimated net sales proceeds. The sale is subject to regulatory approvals and is expected to close by April 30, 2004.

Results of Operations

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

	Years Ended December 31,		
	2003	2002	2001
OPERATING REVENUES:			
Medical Premiums	64.8 %	67.1 %	65.2 %
Military Contract Revenues	31.3	29.2	30.7
Professional Fees	2.5	2.4	2.6
Investment and Other Revenues	1.4	1.3	1.5
Total	100.0	100.0	100.0
OPERATING EXPENSES:			
Medical Expenses	51.4	55.7	55.2
Military Contract Expenses	30.5	28.2	30.0
General and Administrative Expenses	9.2	10.5	11.1
Total	91.1	94.4	96.3
OPERATING INCOME FROM CONTINUING OPERATIONS	8.9	5.6	3.7
INTEREST EXPENSE	(0.4)	(0.6)	(1.4)
OTHER INCOME (EXPENSE), NET	--	--	(0.2)
INCOME FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	8.5	5.0	2.1
PROVISION FOR INCOME TAXES	(3.0)	(1.7)	(0.7)
INCOME FROM CONTINUING OPERATIONS	5.5	3.3	1.4
LOSS FROM DISCONTINUED OPERATIONS	(1.3)	(0.5)	(1.1)
NET INCOME	4.2 %	2.8 %	0.3 %

Year Ended December 31, 2003 Compared to 2002

Total Operating Revenues

increased approximately 16.1% to $1.49 billion from $1.28 billion for 2002.

The change in operating revenues was comprised of the following:

- An increase in medical premiums of $104.5 million
- An increase in military contract revenues of $91.7 million
- An increase in professional fees of $6.5 million
- An increase in investment and other revenues of $3.8 million

Medical Premiums

from our HMO and managed indemnity insurance subsidiaries increased from $857.7 million to $962.2 million, an increase of $104.5 million or 12.2%. The increase in premium revenue reflects a 7.2% increase in Medicare member months (the number of months individuals are enrolled in a plan), a 19.9% increase in Medicaid member months and a 4.8% 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 approximately 13% while the overall recorded per member per month revenue increase, including new and continuing business, was approximately 11%. Managed indemnity rates on renewing groups increased approximately 9%. We did not receive a Medicaid rate increase in 2002 or 2003. The basic Medicare rate increase received in 2003 was approximately 2.0%. Our overall Medicare rate increase was approximately 2.8% due primarily to an increase in the Social HMO membership as a percentage of our total Medicare membership.

Effective January 2004, the Centers for Medicare and Medicaid Services, or CMS, has adopted a new risk adjustment payment methodology for Medicare beneficiaries who are enrolled in managed care programs, including the Social HMO. In addition, CMS has revised the payment factors for the Social HMO members to include a frailty adjuster that uses measures of functional impairment to predict expenditures. Under the new payment methodology, in 2004, we will be paid 90% based on the current payment approach and 10% based on the new approach. The Social HMO program was due to expire at the end of 2003; however CMS administratively extended the Social HMO program for one year, through 2004. If the Social HMO contract is not renewed beyond 2004, we would seek to transfer the members into one of our traditional Medicare plans. This transfer would allow for the continuity of care of our members but without the additional Social HMO specific benefits that are currently available to them and the associated higher premiums we receive. There are activities taking place on a federal level to continue the program, but there is no guarantee at this time that the Social HMO contract will be renewed beyond 2004. Continued medical premium revenue growth is principally dependent upon continued enrollment in our products and upon competitive and regulatory factors.

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA, and effective March 2004, we have calculated that the MMA will increase our Medicare premium rates by over 15%. The increased funding must be used in one or more of the following ways: to reduce beneficiary premiums; reduce beneficiary cost sharing; enhance benefits; placed into a benefit stabilization fund; or used to retain providers or expand the provider network as long as the provider network stabilization or enhancement does not result in increased premiums, increased cost sharing or reduced benefits. We proposed to use the additional funding to enhance various plan benefits, including a reduction in the

amount of Medicare Part B premium that our members pay to the Federal government, and to stabilize our provider network.

Our commercial membership increased from 187,000 at December 31, 2002 to 202,000 at December 31, 2003. In the first two months of 2004, we have added almost 9,000 additional members. Our commercial member retention was approximately 95% for our January 2004 renewals, which represent approximately 50% of our total commercial membership. The increase in commercial membership during 2003 is primarily attributed to in-case growth, movement from self-insured plans to our commercial products and new accounts.

Military Contract Revenues

increased from $373.6 million to $465.3 million, an increase of $91.7 million or 24.6%. Included in the total military contract revenues are incremental change order and bid price adjustments for 2002 and 2003 of $149 million and $148 million, respectively. The increase in revenue is the result of higher base contract revenue primarily due to increased eligible beneficiaries from the call up of reservists in Region 1 and their family members who are eligible for the TRICARE program after 30 days and the positive impact of the first year of our contract extension, which began June 2003. The base monthly revenue under the contract extension is higher than it was under the previous contract. There were no final settlements of bid price adjustments in 2002 or 2003.

SMHS completed the fifth year of a five-year contract in May 2003 and is in the first year of a contract extension. In August 2002, the DoD requested proposals for managed care services under the Next Generation TRICARE, or T-Nex, contract. We submitted our proposal in January 2003 for the T-Nex North Region contract, which includes Region 1, as well as Michigan, Ohio, Kentucky, Indiana, Illinois, Wisconsin, Virginia and North Carolina. However, in August 2003, the DoD awarded the T-Nex North Region contract to a competitor and the General Accounting Office denied our protest of the award in December 2003. The new contractor is scheduled to be operational in Region 1 on September 1, 2004 and the new contract would supersede the remainder of our current TRICARE Region 1 contract. After the new contractor is operational on September 1, 2004, SMHS will commence a six-month phase-out of operations at prices previously negotiated with the DoD. SMHS does not meet the definition of discontinued operations since we do not have plans to dispose of the operations before the phase-out is complete. For more detail on SMHS' results of operations see Note 19, Segment Reporting, in the Notes to the Consolidated Financial Statements.

Professional Fees

increased from $30.9 million to $37.4 million, an increase of $6.5 million, or 20.8% as a result of increased visits due to membership growth, a higher percentage of members selecting our owned medical group and an increase in related services performed by our other provider subsidiaries.

Investment and Other Revenues

increased from $16.4 million to $20.2 million, an increase of $3.8 million or 23.4%. Investment revenues increased due to higher average invested balances, an increase in net gains on the sale of investments of $600,000 and an increase in revenues associated with administrative services of $1.1 million.

Medical Expenses

increased from $712.3 million to $762.9 million, an increase of $50.6 million or 7.1%. The increase is due primarily to our increased membership, which is in part offset by a lower medical care ratio. This ratio, which is medical expenses as a percentage of medical premiums and professional fees, decreased to 76.3% from 80.2%. The favorable decrease in our medical care ratio is due primarily to premium increases in excess of cost increases, lower average cost per hospital bed day as a result of a new hospital contract we entered into in the third quarter of 2002, favorable pharmacy costs and favorable claims development from prior periods. The favorable decrease was partially offset by malpractice cost

increases at our medical provider subsidiary. The number of days in claims payable, which is the medical claims payable balance divided by the average medical expense per day for the period, at December 31, 2003 was 50.0 compared to 49.6 at December 31, 2002.

Our medical claims payable liability requires us to make significant estimates. Any changes to the estimates would be reflected in the year the adjustments are made. Included in medical expenses is favorable development on prior years' estimates of $14.0 million and $10.9 million for the years ended December 31, 2003 and 2002, respectively. The favorable development is a result of claims being settled for amounts less than originally estimated.

We contract with hospitals, physicians and other independent contracted providers of health care under capitated or discounted fee-for- service arrangements, including hospital per diems, to provide medical care services to members. Capitated providers are at risk for a portion of the cost of medical care services provided to our members in the relevant geographic areas; however, we are ultimately responsible for the provision of services to our members should the capitated provider be unable to provide the contracted services. We incurred capitation expenses of $101.8 million and $88.8 million, or 13.3% and 12.5%, of our total medical expenses for 2003 and 2002, respectively.

Military Contract Expenses

increased from $360.4 million to $452.6 million, an increase of $92.2 million or 25.6%. The increase is consistent with the increase in revenues discussed previously and includes $9.4 million in T-Nex related costs for 2003 compared to $5.1 million in 2002. 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 707,000 eligible individuals of active duty military personnel, military retirees under the age of 65 and dependents of military retirees through a network of approximately 49,700 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.

Included in military contract expenses is favorable development of prior years' estimates having an earnings impact of $3.2 million and $4.6 million for the years ended December 31, 2003 and 2002, respectively. In addition, favorable development of prior years estimates having a non- earnings impact were $10.8 million and $16.5 million for 2003 and 2002, respectively. The non-earnings impact was offset by a reduction in military contract revenues pursuant to the gain/loss risk-sharing with the government. The favorable development was a result of claims being settled for amounts less than originally estimated.

General and Administrative Expenses,

or G&A, increased from $134.0 million to $137.3 million, an increase of approximately $3.3 million or 2.4%. G&A expenses increased due to increases in payroll and benefits and facility lease expense partially offset by a decrease in legal expenses. 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. As a percentage of revenues, G&A expenses were 9.2% for 2003, compared to 10.5% in 2002 as result of the items described above and the overall increase in revenues. As a percentage of medical premium revenue, G&A expenses were 14.3% for 2003, compared to 15.6% for 2002 due to the overall increase in medical premium revenue.

Interest Expense

decreased from $7.7 million to $5.5 million, a decrease of approximately $2.2 million or 28.2%. Interest expense related to the sale-leaseback transaction decreased by approximately $2.8 million as the remaining buildings qualified as a sale during 2002. The decrease in the interest expense related to our revolving credit facility was primarily offset by an increase in interest related to the new senior convertible debentures. We currently incur a fee of 0.375% on the unused portion of our new revolving credit facility.

Other Income (Expense), Net

resulted in expense of approximately $200,000 for 2003 compared to income of approximately $55,000 for 2002.

Provision for Income Taxes

was recorded at $44.6 million for 2003 compared to $22.1 million for 2002. The effective tax rate for 2003 was 35.2% compared to 34.3% for 2002. Our effective tax rate is greater than the statutory rate due primarily to an increase in state income taxes.

Discontinued Operations

consist of our Texas HMO health care operations and the CII workers' compensation operations. The net loss from discontinued operations for 2003 was approximately $19.8 million compared to $5.9 million for 2002. The Texas HMO health care operations had net income of approximately $3.1 million for 2003, which was offset by a net loss on the CII workers' compensation operations of $22.9 million.

Discontinued Texas HMO health care operations.

The income from the Texas HMO health care operations for 2003 included a pre-tax gain on the early payoff of the remaining Kaiser-Texas mortgage loan of $2.1 million, a net decrease in litigation accruals of $3.0 million and, favorable development in medical claim liabilities of $1.8 million partially offset by a loss on the sale/write down of real estate of approximately $400,000 and other operating expense and adjustments of $1.7 million. The combined adjustments resulted in income from the discontinued Texas HMO health care operations of $4.8 million pre-tax or net income of $3.1 million.

Discontinued CII workers' compensation operations.

The discontinued workers' compensation operations for 2003 had a net loss of $22.9 million. Net earned premiums decreased by $53.2 million or 30.2% due primarily to a decrease in direct earned premiums of $48.4 million and an increase in ceded reinsurance premiums of $5.7 million partially offset by an increase in assumed premiums of approximately $900,000.

Investment and other revenue decreased by $3.3 million or 26.4% due to a decrease in the average investment yields during the period.

In conjunction with the decision to sell the workers' compensation operations at the end of 2002, 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.

In the second quarter of 2003, we recorded $4.0 million, $2.6 million after tax, in additional valuation adjustments. On November 25, 2003, we announced that we had reached an agreement to sell Cal Indemnity and its subsidiaries. In the fourth quarter of 2003, we recorded a charge of $15.6 million, gross and net of tax, to write down the investment in Cal Indemnity to its estimated net sales proceeds. We did not recognize a tax benefit on the charge since our tax basis was less than our investment in Cal Indemnity. The sale is subject to regulatory approvals and is expected to close by April 30, 2004.

Excluding the $15.6 million charge, expenses decreased in the CII workers' compensation operations by approximately $65.8 million or 31.2%. The decrease is primarily due to the following:

- In 2003, we recorded $16.9 million of net adverse loss development for prior accident years compared to net adverse loss development of $24.0 million recorded in 2002. The net adverse loss development recorded in 2003 was largely attributable to higher costs per claim, or claim severity, in California, primarily on accident years 1997-2002 except 2000. 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 loss adjustment expense, or LAE, ratio for the 2003 accident year compared to the 2002 accident year was lower by 7.0%, which resulted in a decrease in loss and LAE of approximately $8.6 million. The reduction is primarily related to our premium rate increases.

- A $42.1 million reduction in loss and LAE is related to the decrease in net earned premiums in 2003 compared to 2002.

- The net decrease in underwriting expenses, policyholders' dividends and other operating expenses was approximately $8.0 million and is attributable to the lower premium revenue for the period.

The net adverse loss development on prior accident years included those years that were covered by our reinsurance agreements. This resulted in an increase in the reinsurance recoverable balance, which was then reduced by amounts collected from reinsurers. For the year ended December 31, 2003, we increased our ceded reserves by $40.9 million and received payments from our reinsurers totaling $53.0 million.

The loss and LAE reserves recorded as of December 31, 2003 reflect our best estimate of the ultimate loss costs for reported and unreported claims occurring in accident year 2003 as well as those occurring in accident years prior to 2003. 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 was 118.9% compared to 119.6% for 2002. The decrease was primarily due to a decrease in the loss and LAE ratio. Excluding prior accident years' adverse loss development, the combined ratio would have been 105.2% for 2003 and 106.0% for 2002.

New California workers' compensation insurance reform legislation was signed into law in September 2003 to address some of the cost drivers that have led to significantly higher workers' compensation insurance premium rates over the past three years. The Workers' Compensation Insurance Rating Bureau, or WCIRB, has preliminarily indicated that the reform legislation will reduce the 2004 loss costs by an average of 2.9% to 5.3%. Prior to the enactment of the legislation, the WCIRB had indicated that 2004 loss costs should increase by an average of 12%. We have not adjusted our reserving methods and there is no assurance that our rates are adequate given the inherent uncertainties in any new legislation.

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, have reduced coverage limits and 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.

Reinsurance contracts do not relieve us from our obligations to injured workers or policyholders. At December 31, 2003, we had $177.3 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, 2003, no allowance was established. At December 31, 2003, all of our reinsurers were rated A- or better by Fitch Ratings (7th of 23) and the A.M. Best Company (4th of 16). Should these companies be unable to perform their obligations to reimburse us for ceded losses, we would experience significant losses.

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 from $719.0 million to $857.7 million, an increase of $138.7 million or 19.3%. The 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.

Military Contract Revenues

increased from $338.9 million to $373.6 million, an increase of $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. In addition, the 2001 revenue included final bid price adjustments on the first two completed option periods of the TRICARE Region 1 contract. The final adjustments resulted in revenue reductions of approximately $300,000 for Option Period 1 (June 1998 to May 1999), which is 0.2% of the final revenue settlement amount for that period and $1.8 million for Option Period 2 (June 1999 to May 2000), which is 0.9% of the final revenue settlement amount for that period. The impact on the 2001 net income for the final bid price adjustments for the first two completed option periods, net of corresponding expense adjustments noted below, was a reduction of $1.0 million. There were no final settlements of bid price adjustments in 2002.

The 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

age 65 and over. 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.

Professional Fees

increased from $29.0 million to $30.9 million, an increase of $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 from $16.6 million to $16.4 million, a decrease of 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.

Medical Expenses

increased from $608.8 million to $712.3 million, an increase of $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 and favorable claims development from prior periods, which were partially offset by higher bed days in 2002. Included in medical expenses is favorable development on prior years' estimates of $10.9 million and $7.5 million for the years ended December 31, 2002 and 2001, respectively. The favorable development is a result of claims being settled for amounts less than originally estimated.

Military Contract Expenses

increased from $331.6 million to $360.4 million, an increase of $28.8 million or 8.7%. The increase is consistent with the increase in revenues discussed previously. In addition, the 2001 contract expenses included final bid price adjustments on the first two completed option periods of the TRICARE Region 1 contract. The final adjustments resulted in a contract expense increase of approximately $600,000 for Option Period 1, which is 0.3% of the final contract expense settlement amount for that period and a contract expense reduction of $1.2 million for Option Period 2, which is 0.6% of the final contract expense settlement amount for that period. There were no final settlements of bid price adjustments in 2002.

Included in military contract expenses are favorable development of prior years' estimates having an earnings impact of $4.6 million for the year ended December 31, 2002 and unfavorable development on prior years' estimates having an earnings impact of $2.1 million for the year ended December 31, 2001. In addition, favorable development of prior years estimates having a non-earnings impact were $16.5 million and $11.9 million for 2002 and 2001, respectively. The non-earnings impact was offset by a reduction in military contract revenues pursuant to the gain/loss risk-sharing with the government. The favorable development was a result of claims being settled for amounts less than originally estimated.

General and Administrative Expenses,

or G&A, increased from $122.6 million to $134.0 million, an increase of $11.4 million or 9.3%. 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.

Interest Expense

decreased from $15.7 million to $7.7 million, a decrease of $8.0 million or 51.4%. 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 incurred a fee of 0.5% on the unused portion of the

revolving credit facility. Interest expense related to the sale-leaseback transaction decreased by $4.9 million as the remaining buildings qualified as a sale during 2002. We had various increases in interest expense of approximately $600,000.

Other Income (Expense), Net

increased $2.2 million primarily due to a net loss on sale of assets of $2.3 million in 2001.

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 $14.4 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 $14.4 million compared to a profit of $2.0 million in 2001. The 2002 results included valuation adjustments of $17.3 million, or $11.3 million after tax. 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.

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 was 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.

- 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, 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 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 of 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.

LIQUIDITY AND CAPITAL RESOURCES

We had cash flows from operating activities for continuing operations of $151.9 million for the year ended December 31, 2003 compared to $136.6 million in 2002. We used the majority of the cash flow for the repurchase of the Company's common stock and for capital expenditures. The improvement in cash flows from continuing operations over 2002 is primarily attributable to cash from earnings and the change in operating assets and liabilities.

The cash flow resulting from the change in operating assets and liabilities of $49.5 million was primarily due to the following:

- a source of cash due to the decrease in the deferred tax asset balance of $32.7 million

- a source of cash due to the increase in medical claims payable of $5.7 million
- a source of cash due to the increase in other liabilities of $9.0 million
- a source of cash due to the increase in other current liabilities of $21.3 million
- a source of cash due to the increase in military health care payable balance of $11.4 million
- a use of cash due to the increase in other assets of $7.4 million
- a use of cash due to the increase in other current assets of $19.1 million
- various other changes in assets and liabilities accounting for the remaining use of cash of $4.1 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. 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.

The loss of the T-Nex contract will adversely affect our cash flow from operations starting in the fourth quarter of 2004. During the phase-out period, we expect that SMHS will have negative cash from operations as the payout of the remaining liabilities will exceed SMHS' accounts receivable balance.

Net cash used for investing activities of continuing operations during 2003 included $21.8 million in capital expenditures associated with the continued implementation of new computer systems, leasehold improvements on facilities, furniture and equipment and other capital purchases to support our growth. This was offset by net proceeds of $3.3 million from property and equipment dispositions. The net cash change in investments for the year was an increase in investments of $12.5 million as investments were purchased with available funds.

Net cash used for financing activities of continuing operations during 2003 included net payments of $60.7 million on debt related items offset by $115.0 million in proceeds from the sale of our senior convertible debentures and $1.5 million from proceeds of other long-term debt. These proceeds were offset by debt issue costs of $5.8 million. Proceeds from the issuance of stock in connection with stock plans were $19.2 million. We used cash of $99.5 million to purchase treasury stock.

On December 28, 2000, the majority of our Las Vegas, Nevada administrative and medical clinic real estate holdings were sold in a sale-leaseback transaction. As part of the transaction, a portion of the sales price was financed with mortgage notes receivable of $22.2 million and deposits of $4.3 million were provided. 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.

Discontinued operations used cash of $17.8 million in 2003, compared to $47.9 million in 2002. Cash used in 2003 was primarily for the payoff of the remaining Kaiser-Texas mortgage loan for $12.9 million and the redemption of the outstanding 9½% senior debentures for $15.3 million. Cash used in 2002 was primarily for the run-out of claims and other legal and restitution related items. Based on the current estimated Texas HMO health care run-out costs and recorded reserves, we believe we have adequate funds available and the ability to invest, should we be required to do so, adequate funds in Texas to meet the anticipated obligations for our former members' health care claims.

Sierra Debentures

In March 2003, we issued $115.0 million aggregate principal amount of 2¼% senior convertible debentures due March 15, 2023. The debentures pay interest, which is due semi-annually on March 15 and September 15 of each year. Each $1,000 principal amount of debentures is convertible, at the option

of the holders, into 54.6747 shares of Sierra Health Services, Inc., common stock prior to March 15, 2023 if (i) the market price of our common stock for at least 20 trading days in a period of 30 consecutive trading days ending on the last trading day of the preceding fiscal quarter exceeds 120% of the conversion price per share of our common stock; (ii) the debentures are called for redemption; (iii) there is an event of default with respect to the debentures; or (iv) specified corporate transactions have occurred. The conversion rate is subject to certain adjustments. This conversion rate initially represents a conversion price of $18.29 per share. Holders of the debentures may require us to repurchase all or a portion of their debentures on March 15 in 2008, 2013 and 2018 or upon certain corporate events including a change in control. In either case, we may choose to pay the purchase price of such debentures in cash or common stock or a combination of cash and common stock. The debentures can be redeemed by us for cash beginning on or after March 20, 2008.

The debentures were sold to Banc of America Securities LLC, Credit Lyonnais Securities (USA), Inc., and U.S. Bancorp Piper Jaffray, in reliance upon the exemption afforded by Section 4(2) of the Securities Act, and were offered and resold to "qualified institutional buyers" under Rule 144A of the Securities Act. We filed a registration statement under the Securities Act to permit registered resales of the debentures and the common stock into which the debentures are convertible. The Securities and Exchange Commission declared this registration statement effective on August 29, 2003.

The aggregate offering price of the debentures was $115.0 million, 100% of the principal amount thereof. The purchase price paid to the Company by the initial purchasers was the initial offering price less a discount of $3.5 million or 3.0% of the principal amount of the debentures. The Company used the net proceeds of the offering to repay the $39.0 million outstanding under the then existing credit facility and to contribute $35.0 million to SMHS. The Company also used $19.9 million of the proceeds to purchase 1.6 million shares of the Company's common stock under its repurchase program. The remainder of the net proceeds were used for working capital and general corporate purposes including additional share repurchases.

Revolving Credit Facility

On March 3, 2003, we entered into a new $65.0 million revolving credit facility, which replaced 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 was initially LIBOR plus 2.25% and is currently LIBOR plus 2.00%. 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. We have not yet utilized this facility.

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 limit 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, repurchase our common stock or make capital

expenditures and otherwise restricts certain corporate activities. In addition, we are required to comply with specified financial ratios as set forth in the new credit agreement. We believe that we are in compliance with all covenants of the new credit agreement.

Sierra Share Repurchase Program

As of December 31, 2003, our Board of Directors had authorized a program for the repurchase of up to 7.6 million shares of our common stock. Through December 31, 2003, we had purchased, at prevailing prices in the open market by block purchase or private transactions, 5.3 million shares for $99.5 million. As of December 31, 2003, we had Board authorization to purchase approximately 2.3 million shares of common stock.

Our new revolving credit facility, as amended, allows for additional stock repurchases of up to $60 million during the remainder of 2004. As of March 1, 2004, the Company has repurchased an additional 708,000 shares for $22.6 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 $36.5 million at December 31, 2003. 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 of $1.5 million and net worth of at least $3.5 million. We believe we are in material compliance with our regulatory requirements.

Of the $177.2 million in cash and cash equivalents held at December 31, 2003, including discontinued operations, $58.7 million was held by discontinued operations and of the remainder, $51.5 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, 2003. The amounts presented below include all future payments associated with each obligation including interest expense.

	Long-Term Debt	Capital Leases	Operating Leases	Total
		(In thousands)		
Continuing Operations				
Payments due in less than 1 year	$ 2,684	$ 117	$ 21,384	$ 24,185
Payments due in 1 to 3 years	5,368	144	40,171	45,683
Payments due in 4 to 5 years	6,146	101	36,408	42,655
Payments due after 5 years	148,918	123	117,471	266,512
Total Continuing Operations	$ 163,116	$ 485	$ 215,434	$ 379,035
Discontinued Operations				
Payments due in less than 1 year	$ --	$ 235	$ 777	$ 1,012
Payments due in 1 to 3 years	--	--	1,388	1,388
Payments due in 4 to 5 years	--	--	969	969
Payments due after 5 years	--	--	--	--
Total Discontinued Operations	$ --	$ 235	$ 3,134	$ 3,369

Other

We have a 2004 capital budget of $16.9 million and are also limited in the amount of capital expenditures we can purchase by our new revolving credit facility. The 2004 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 and debt service. 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.

At December 31, 2002, our Chief Executive Officer, or CEO, had loans outstanding to us in the amount of $4.2 million with a maturity date of December 31, 2003. During 2003, our CEO paid the entire outstanding balance including accrued interest.

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 effected 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 Part 1, Item 1 of this 2003 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 April 2003, the FASB issued Statement of Financial Accounting Standards No. 149, "Amendment of Statement 133 on Derivative Instruments and Hedging Activities" ("SFAS No. 149"), which amends and clarifies financial accounting and reporting for derivative instruments, including certain derivative instruments embedded in other contracts and for hedging activities under SFAS No. 133. SFAS No. 149 is effective for contracts entered into or modified after June 30, 2003, except for the provisions that were cleared by the FASB in prior pronouncements. The adoption of SFAS No.149 did not have a material effect on our consolidated financial position or results of operations.

In December 2003, the FASB, issued Statement of Financial Accounting Standards No. 132 (Revised 2003), "Employers' Disclosures about Pensions and Other Postretirement Benefits, an amendment of

FASB Statements No. 87, 88 and 106" or Revised SFAS No. 132. Revised SFAS No. 132 retains the disclosure requirement contained in the original FASB Statement No. 132, "Employers' Disclosures about Pensions and Other Postretirement Benefits", which it replaces. The statement also requires additional disclosures to those in the original FASB Statement No. 132 about the assets, obligations, cash flows, and net periodic benefit cost of defined benefit pension plans and other postretirement plans. See Note 15 for disclosure on our defined benefit plan.

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 disclosure of 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 materially 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, 2003, our allowance for retroactive adjustments for health care premium revenues was $2.2 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, 2003, represented 10.6% of our total consolidated liabilities or $103.7 million, is 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, 2003, would reduce reported net income for the year 2003 by $674,000 or 1.1% 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, 2003, we estimate that approximately $148 million or 32% of the total military contract revenues were for BPA and change orders. At December 31, 2003, military accounts receivable due from the federal government was $47.4 million of which approximately $9.9 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, 2003, our military health care payable was $76.6 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, 2003, we had total investments for continuing operations of $215.2 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, 2003, and are reported as non-current assets, the remainder of these investments of $197.6 million are available to support current operations and are therefore reported as current assets.

Our discontinued operations had total investments of $247.7 million of which $244.2 million was classified as available-for-sale and the balance of $3.5 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 total investments, including discontinued operations, by 1% at December 31, 2003, our reported net income for the year 2003 would be reduced by $3.0 million or 4.8% 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 currently 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 also 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 five years (1999-2003), 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, 2003, loss and LAE reserves represented 87.9% of the liabilities of discontinued operations and 42.2% 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, 2003, would reduce reported net income for the year 2003 by $2.7 million or 4.3% 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, 2003, reinsurance recoverable for workers' compensation was $177.3 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, 2003, would reduce reported net income for the year 2003 by $1.2 million or 1.8% 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 and depreciation. 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, 2003, our total deferred tax assets, including discontinued operations, were $62.7 million and our total deferred tax liabilities were $5.4 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, 2003, could reduce reported net income for the year 2003 by $623,000 or 1.0% and diluted earnings per share would be reduced by $0.02.

Net Proceeds From the Sale of Cal Indemnity.

On November 25, 2003, we entered into an agreement to sell Cal Indemnity and its insurance subsidiaries. The sale requires regulatory approval and is expected to be completed by April 30, 2004. The cash portion of the purchase price, which will be paid when the agreement becomes effective, is subject to certain adjustments that will not be determined until the transaction is consummated. The value of certain assets will be subject to further adjustments at future dates. The contingent payment portion of the purchase price will be based on the development that occurs on the loss and allocated loss adjustment expense reserves from the consummation date through December 31, 2009. In addition, we will be obligated to perform, or be responsible for the performance of, certain transition services through December 31, 2009 for which we will receive a limited amount of funds for these services.

In the fourth quarter of 2003, we recorded a charge of $15.6 million, gross and net of tax, to write-down the investment in Cal Indemnity to its estimated net sales proceeds of approximately $73 million. We did not recognize a tax benefit on the charge since our tax basis was less than our investment in Cal Indemnity. We used estimates and assumptions to project Cal Indemnity's future operating results, the costs to perform transition services, the funds to be received for transition services, the expected value of certain assets, the development of loss and allocated loss adjustment expense reserves, and the sales transaction costs. Prior to the effective date, any change to the net sales proceeds will be included in the results for discontinued operations. After the effective date, any change to the net sales proceeds will be included in operating results of continuing operations. A change to the net sales proceeds could

have a material effect on our financial results. For example, a 1% decrease in the net sales proceeds as of December 31, 2003, would have reduced our reported net income for the year 2003 by $730,000 or 1.2% and diluted earnings per share would be reduced by $.02.

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.

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, 2003, including discontinued operations, we have approximately $640.1 million in cash and cash equivalents and current, long-term and restricted investments. Of the total investments of $462.9 million, approximately $459.4 million are classified as available-for-sale and $3.5 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 $9.1 million after tax (6.1% of total stockholders' equity). Of the $9.1 million decrease, $4.6 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.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

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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, 2003, 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.

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

/s/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, 2003 and 2002, and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2003. 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, 2003 and 2002, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2003, 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 20 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.

/s/DELOITTE & TOUCHE LLP
Las Vegas, Nevada
March 4, 2004

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
December 31, 2003 and 2002
(In thousands, except share data)

	2003	2002
ASSETS		
CURRENT ASSETS: Cash and Cash Equivalents	$ 118,473	$ 45,778
Investments	197,573	182,452
Accounts Receivable (Less Allowance for Doubtful Accounts: 2003 - $7,342; 2002 - $10,626)	12,080	11,232
Military Accounts Receivable (Less Allowance for Doubtful Accounts: 2003 and 2002 - $100)	47,389	47,126
Current Portion of Deferred Tax Asset	33,708	50,402
Prepaid Expenses and Other Current Assets	37,478	18,380
Assets of Discontinued Operations	533,756	565,058
Total Current Assets	980,457	920,428
PROPERTY AND EQUIPMENT, NET	63,109	64,868
RESTRICTED CASH AND INVESTMENTS	17,646	17,557
GOODWILL (Less: Accumulated Amortization $6,972)	14,782	14,782
DEFERRED TAX ASSET (Less Current Portion)	11,501	14,947
OTHER ASSETS	46,626	33,384
TOTAL ASSETS	$ 1,134,121	$ 1,065,966
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES: Accrued Liabilities	$ 56,327	$ 50,349
Trade Accounts Payable	37,787	29,249
Accrued Payroll and Taxes	15,879	13,660
Medical Claims Payable	103,749	98,031
Unearned Premium Revenue	45,888	40,758
Military Health Care Payable	76,605	65,223
Current Portion of Long-Term Debt	163	186
Liabilities of Discontinued Operations	472,407	500,720
Total Current Liabilities	808,805	798,176
LONG-TERM DEBT (Less Current Portion)	116,645	60,710
OTHER LIABILITIES	57,907	50,515
TOTAL LIABILITIES	983,357	909,401
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; 2003 - 33,173; 2002 - 30,953 Shares Issued	166	155
Treasury Stock: 2003 - 6,221; 2002 - 1,163 Common Stock Shares..	(112,737)	(17,148)
Additional Paid-In Capital	227,417	196,711
Deferred Compensation	(22)	(473)
Accumulated Other Comprehensive (Loss) Gain	(479)	381
Retained Earnings (Accumulated Deficit)	36,419	(23,061)
TOTAL STOCKHOLDERS' EQUITY	150,764	156,565
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 1,134,121	$ 1,065,966

See the accompanying notes to consolidated financial statements.

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
For the Years Ended December 31, 2003, 2002 and 2001
(In thousands, except per share data)

	2003	2002	2001
OPERATING REVENUES:			
Medical Premiums	$ 962,176	$ 857,741	$ 718,
Military Contract Revenues	465,313	373,589	338,
Professional Fees	37,367	30,923	28,
Investment and Other Revenues	20,223	16,382	16,
Total	1,485,079	1,278,635	1,103,
OPERATING EXPENSES:			
Medical Expenses	762,865	712,290	608,
Military Contract Expenses	452,554	360,375	331,
General and Administrative Expenses	137,263	133,979	122,
Total	1,352,682	1,206,644	1,063,
OPERATING INCOME FROM CONTINUING OPERATIONS	132,397	71,991	40,
Interest Expense	(5,491)	(7,650)	(15,
Other Income (Expense), Net	(223)	55	(2,
INCOME FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	126,683	64,396	22,
PROVISION FOR INCOME TAXES	(44,565)	(22,088)	(7,
INCOME FROM CONTINUING OPERATIONS	82,118	42,308	15,
LOSS FROM DISCONTINUED OPERATIONS (net of income tax benefit of $3,578, $2,945 and $5,403)	(19,792)	(5,860)	(11,
NET INCOME	$ 62,326	$ 36,448	$ 3,
EARNINGS PER COMMON SHARE:			
Income From Continuing Operations	$ 2.93	$ 1.47	$ 0
Loss from Discontinued Operations	(0.71)	(0.20)	(0
Net Income	$ 2.22	$ 1.27	$ 0
EARNINGS PER COMMON SHARE ASSUMING DILUTION:			
Income From Continuing Operations	$ 2.70	$ 1.36	$ 0
Loss from Discontinued Operations	(0.65)	(0.19)	(0
Net Income	$ 2.05	$ 1.17	$ 0

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, 2003, 2002 and 2001
(In thousands)

	Common Stock	In Treasury	Add P

	Shares	Amount	Shares	Amount	C
BALANCE, JANUARY 1, 2001	28,815	$ 144	1,523	$ (22,789)	$
Common Stock Issued in Connection with Stock Plans	589	3	--	--	
Income Tax Benefit Realized Upon Exercise of Stock Options	--	--	--	--	
Issuance of Restricted Stock	244	1	--	--	
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)	
Common Stock Issued in Connection with Stock Plans	1,305	7	(360)	5,641	
Income Tax Benefit Realized Upon Exercise of Stock Options	--	--	--	--	
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)	
Common Stock Issued in Connection with Stock Plans	2,220	11	(272)	3,896	
Income Tax Benefit Realized Upon Exercise of Stock Options	--	--	--	--	
Amortization of Deferred Compensation	--	--	--	--	
Repurchase of Common Shares	--	--	5,330	(99,485)	
Comprehensive Income:					
Net Income	--	--	--	--	
Other Comprehensive Income:					
Unrealized Holding Loss on Available-for-Sale Investments ($4,446 pretax)	--	--	--	--	
Reclassification Adjustment for Gains Included in Net Income ($1,493 pretax)	--	--	--	--	
Minimum Pension Liability Adjustment ($1,630 pretax)	--	--	--	--	
Total Comprehensive Income	--	--	--	--	
BALANCE, DECEMBER 31, 2003	33,173	$ 166	6,221	$(112,737)	$

See the accompanying notes to consolidated financial statements.

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SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 2003, 2002 and 2001
(In thousands)

	2003	2002	
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net Income	$ 62,326	$ 36,448	$
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:			
Loss from Discontinued Operations	19,792	5,860	
Depreciation and Amortization	15,929	18,245	
Deferred Compensation Expense	451	585	
Provision for Doubtful Accounts	3,071	2,835	
Loss on Property and Equipment Dispositions	825	17	
Change in Operating Assets and Liabilities:			
Other Assets	(7,408)	(16)	
Deferred Tax Asset	32,688	37,931	
Other Current Liabilities	21,345	14,660	
Accounts Receivable	(3,919)	1,267	
Other Current Assets	(19,097)	6,454	
Military Accounts Receivable	(263)	(6,960)	
Military Health Care Payable	11,382	(12,038)	
Medical Claims Payable	5,718	16,369	
Other Liabilities	9,023	14,980	
Net Cash Provided by Operating Activities of Continuing Operations	151,863	136,637	
CASH FLOWS FROM INVESTING ACTIVITIES:			
Capital Expenditures	(21,774)	(12,392)	
Property and Equipment Dispositions	3,256	680	
Purchase of Available-for-Sale Investments	(540,206)	(847,437)	(
Proceeds from Sales/Maturities of Available-for-Sale Investments	527,696	712,483	
Net Cash Used for Investing Activities of Continuing Operations	(31,028)	(146,666)	
CASH FLOWS FROM FINANCING ACTIVITIES:			
Proceeds from Long-term Borrowing	116,480	--	
Debt Issue Costs	(5,834)	--	
Proceeds on Sale-Leaseback Deposit	--	16,862	
Payments on Debt and Capital Leases	(60,721)	(30,399)	
Purchase of Treasury Stock	(99,485)	--	
Exercise of Stock in Connection with Stock Plans	19,171	10,159	
Net Cash Used for Financing Activities of Continuing Operations	(30,389)	(3,378)	
NET CASH USED FOR DISCONTINUED OPERATIONS	(17,751)	(47,929)	
NET INCREASE (DECREASE) IN CASH AND			

CASH EQUIVALENTS	72,695	(61,336)	
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	45,778	107,114	
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 118,473	$ 45,778	$

See the accompanying notes to consolidated financial statements.

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
For the Years Ended December 31, 2003, 2002 and 2001

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 are 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.

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 2001. The Company ceased providing HMO health care coverage in Texas on April 17, 2002.

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

In accordance with SFAS No. 144, during the fourth quarter of 2002, the Company reclassified its workers' compensation insurance operations as discontinued operations. During the fourth quarter of 2003, the Company announced that it and its wholly-owned subsidiary, CII Financial Inc. ("CII"), entered into a Stock Purchase Agreement, which provides for the sale of all of the capital stock of California Indemnity Insurance Company ("Cal Indemnity"), a wholly-owned subsidiary of CII.

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 9 and 10 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, 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 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 $375.2 million, $340.1 million and $304.7 million in 2003, 2002 and 2001, 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 health care component of the TRICARE contract has a fixed bid price component (established when the contract was awarded based on the government's assumptions regarding enrollment and utilization), as well as a Bid Price Adjustment ("BPA") component. The BPA is used to adjust the fixed bid price health care component up or down over the course of the contract for changes in health care cost trends due to changes in enrollment and utilization patterns from the government's original assumed enrollment and utilization patterns. On a monthly basis, SMHS records the base bid health care revenue component as stated in the original bid and SMHS also records an estimate for the BPA using the latest government provided data. SMHS adjusts each BPA accrual as it is provided with new government data. After each BPA negotiation with the government is completed, SMHS records a final BPA adjustment for the ultimate negotiated amount.

While the BPA relates to the original contract and is an ongoing part of the contract, modifications to the original contract are referred to by the Company as change orders. The government negotiates both the cost and profit to be paid on each contract modification. As SMHS incurs costs under the government's direction to proceed with a modification to the contract, the government is contractually obligated to reimburse SMHS for all of its incremental,

allowable costs incurred through the final negotiation date. The allowable costs are those costs determined in accordance with Federal Acquisition Regulation Part 31. Revenue is realizable and earned when SMHS starts performing as contractually required, even though the change order profit has not been fully negotiated. As costs are incurred, SMHS records an estimate of its revenue earned under the modification. The estimate recorded does not include profit until the profit is determined when it is negotiated and finalized with the government. Enrollment fees collected in advance of the service period are recorded as unearned premium revenue and are earned over the service period.

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 and allowances for doubtful accounts.

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. 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 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, 2003, 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 that subsequent year's operating results.

The Company contracts with hospitals, physicians and other independent 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 707,000 dependents of active duty military personnel, military retirees under the age of 65 and

dependents of military retirees through a network of approximately 49,700 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 amounts due from military treatment facilities, 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, LLC. SMHS Funding, LLC 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, 2003, SMHS has not utilized the facility and was 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. On February 17, 2004, SMHS terminated the securitization arrangement with General Electric Capital Corporation.

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 $2.2 million, $2.3 million and $1.7 million, net of reinsurance recoveries of $2.3 million, $1.3 million and $1.8 million, are included in medical expenses for 2003, 2002 and 2001, respectively.

See Note 10 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. The Company capitalizes interest expense as part of the cost of construction of facilities and the implementation of computer systems. 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.

The goodwill balance at December 31, 2003, was $14.8 million, all of which is part of the managed care and corporate operations segment. During 2003 and 2002, the Company's assessment of goodwill resulted in no impairment of goodwill. Amortization expense, from continuing operations, associated with goodwill was $805,000 for the year ended December 31, 2001. See Note 20 for a pro forma table presenting the results of operations as though SFAS No. 142 occurred as of January 1, 2001.

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 2003 and 2002, at amounts below their cost of $2.8 million and $4.3 million, respectively were charged to retained earnings (accumulated deficit), as the Company did not previously have gains in

additional paid-in capital. All sales of treasury shares in 2003 and 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 16. In December 2002, the Financial Accounting Standards Board ("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, "Accounting for Stock-Based Compensation" ("SFAS No. 123"). 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 Company has continued to account for its stock-based compensation using the intrinsic value method prescribed by Accounting Principles Board Opinion No. 25, "Accounting for Stock Issued to Employees," as amended. Accordingly, no compensation cost has been recognized for the Company's employee stock plans except for those expenses associated with the restricted stock units. 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,		
	2003	2002	2001
	(In thousands, except per share data)		
Net income, as reported	$ 62,326	$ 36,448	$ 3,486
Less: total stock-based employee compensation expense determined under fair value based methods for all awards, net of tax	(7,173)	(4,598)	(3,506)
Pro forma net income (loss)	$ 55,153	$ 31,850	$ (20)
Net income per share, as reported	$ 2.22	$ 1.27	$ 0.13
Pro forma net income	1.97	1.11	--
Net income per share assuming dilution, as reported	$ 2.05	$ 1.17	$ 0.12
Pro forma net income	1.81	1.02	--

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 applied to

all the years of previous option grants. The above numbers do not include the effect of options granted prior to 1995. See Note 16 for a discussion of the assumptions used in the option pricing model and estimated fair value of employee stock options.

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 and depreciation.

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 Nevada and California. However, the Company is licensed and does business in several other states. In addition, as of December 31, 2003, the Company had receivables outstanding from the federal government related to its TRICARE contract in the amount of $47.4 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 A- or better by Fitch Ratings (7th of 23) and the A.M. Best Company (4th of 16).

Recently Issued Accounting Standards.

In April 2003, the FASB issued Statement of Financial Accounting Standards No. 149, "Amendment of Statement 133 on Derivative Instruments and Hedging Activities" ("SFAS No. 149"), which amends and clarifies financial accounting and reporting for derivative instruments, including certain derivative instruments embedded in other contracts and for hedging activities under SFAS No. 133. SFAS No. 149 is effective for contracts entered into or modified after June 30, 2003 except for the provisions that were cleared by the FASB in prior pronouncements. The adoption of SFAS No. 149 did not have a material effect on the Company's consolidated financial position or results of operations.

In December 2003, the FASB, issued Statement of Financial Accounting Standards No. 132 (Revised 2003), "Employers' Disclosures about Pensions and Other Postretirement Benefits, an amendment of FASB Statements No. 87, 88 and 106" ("Revised SFAS No. 132"). Revised SFAS No. 132 retains the disclosure requirement contained in

the original FASB Statement No. 132, "Employers' Disclosures about Pensions and Other Postretirement Benefits", which it replaces. The statement also requires additional disclosures to those in the original FASB Statement No. 132 about the assets, obligations, cash flows, and net periodic benefit cost of defined benefit pension plans and other postretirement plans. See Note 15 for disclosure on our defined benefit plan.

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, goodwill, accrued liabilities, malpractice reserves, 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, 2002 and 2001 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,		
	2003	2002	2001
	(In thousands, except per share data)		
Income from continuing operations	$ 82,118	$ 42,308	$ 15,481
Loss from discontinued operations	(19,792)	(5,860)	(11,995)
Net income	$ 62,326	$ 36,448	$ 3,486
Earnings per common share:			
Income from continuing operations	$ 2.93	$ 1.47	$ 0.55
Loss from discontinued operations	(0.71)	(0.20)	(0.43)
Net income	$ 2.22	$ 1.27	$ 0.13
Earnings per common share assuming dilution:			
Income from continuing operations	$ 2.70	$ 1.36	$ 0.54
Loss from discontinued operations	(0.65)	(0.19)	(0.42)
Net income	$ 2.05	$ 1.17	$ 0.12

Weighted average common shares outstanding.....	28,053	28,756	27,685
Dilutive options outstanding.....	2,246	2,141	787
Restricted shares outstanding.....	122	244	37
Weighted average common shares outstanding assuming dilution.....	30,421	31,141	28,509

Stock options to purchase 319,000, 325,000 and 1,591,000 shares in 2003, 2002 and 2001, respectively, were not dilutive and, therefore, were not included in the computations of diluted earnings per share. In addition, the Sierra Debentures were not dilutive at any time during the year ended December 31, 2003. See Note 6 for more information on the Sierra Debentures.

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. **PROPERTY AND EQUIPMENT**

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

	2003	2002
	(In thousands)	
Land.....	$ 2,991	$ 2,984
Buildings and Improvements.....	25,269	22,415
Furniture, Fixtures and Equipment.....	42,058	39,286
Data Processing Equipment and Software.....	98,489	98,216
Software in Development and Construction in Progress.....	202	697
Less: Accumulated Depreciation	(105,900)	(98,730)
Property and Equipment, Net.....	$ 63,109	$ 64,868

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

	2003	2002
	(In thousands)	
Buildings and Improvements.....	$ 245	$ 245
Data Processing Equipment and Software.....	333	333
Vehicles.....	153	--
Less: Accumulated Depreciation.....	(506)	(413)
Property and Equipment, Net.....	$ 225	$ 165

Depreciation expense from continuing operations in 2003, 2002 and 2001 was $15.9 million, $18.2 million and $23.4 million, respectively.

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 2003, 2002 and 2001 were $905,000, $82,000 and $27,000, respectively. Gross realized losses on investments, from continuing operations, for 2003, 2002 and 2001 were $313,000, $84,000 and $92,000, respectively.

The following table summarizes the Company's current and restricted investments, from continuing operations, as of December 31, 2003:

	Amortized Cost	Unrealized Gains	Unr L
		(In thousan	
Available-for-Sale Investments:			
Classified as Current:			
U.S. Government and its Agencies	$ 73,461	$ 168	$
Municipal Obligations	102,469	283	
Mortgage Backed Securities	961	4	
Corporate Bonds	178	8	
Other Debt Securities	18,559	--	
Total Debt Securities	195,628	463	
Preferred Stock	2,663	--	
Total Current	198,291	463	
Classified as Restricted:			
U.S. Government and its Agencies	7,764	99	
Municipal Obligations	2,260	39	
Other Debt Securities	7,505	--	
Total Restricted	17,529	138	
Total Available-for-Sale	$ 215,820	$ 601	$

The fair value of investments with unrealized losses is $116.6 million. The fair value of investments with unrealized losses for more than 12 months is $3.3 million with unrealized losses that total $141,000. The Company has not experienced any investment impairments that were considered other than temporary.

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

Amortized Cost	Gross Unrealized Gains	G Unr L

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

The contractual maturities of available-for-sale debt securities at December 31, 2003 are shown below:

	Amortized Cost	Fair Value
	(In thousands)	
Due in one year or less	$ 70,642	$ 70,709
Due after one year through five years	74,460	74,677
Due after five years through ten years	33,946	33,225
Due after ten years through fifteen years	9,975	9,973
Due after fifteen years	24,134	24,034
Total	$ 213,157	$ 212,618

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 $316.0 million in the accompanying Consolidated Balance Sheet at December 31, 2003, $209.9 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. LONG-TERM DEBT

Debt at December 31, consists of the following:

	2003	2002
	(In thousands)	

2¼% Senior Convertible Debentures	$ 115,000	$ --
Revolving Credit Facility	--	60,000
Other	1,808	896
Total	116,808	60,896
Less Current Portion	(163)	(186)
Long-term Debt	$ 116,645	$ 60,710

Sierra Debentures - In March 2003, the Company issued $115.0 million aggregate principal amount of its 2¼% senior convertible debentures due March 15, 2023. The debentures pay interest, which is due semi- annually on March 15 and September 15 of each year. Each $1,000 principal amount of debentures is convertible, at the option of the holders, into 54.6747 shares of Sierra Health Services, Inc., common stock prior to March 15, 2023 if (i) the market price of the Company's common stock for at least 20 trading days in a period of 30 consecutive trading days ending on the last trading day of the preceding fiscal quarter exceeds 120% of the conversion price per share of the Company's common stock; (ii) the debentures are called for redemption; (iii) there is an event of default with respect to the debentures; or (iv) specified corporate transactions have occurred. The conversion rate is subject to certain adjustments. This conversion rate initially represents a conversion price of $18.29 per share. Holders of the debentures may require the Company to repurchase all or a portion of their debentures on March 15 in 2008, 2013 and 2018 or upon certain corporate events including a change in control. In either case, the Company may choose to pay the purchase price of such debentures in cash or common stock or a combination of cash and common stock. The debentures can be redeemed by the Company for cash beginning on or after March 20, 2008.

The Company evaluates the market price condition each quarter to determine whether the debentures will be convertible, at the option of the holder, during the subsequent quarter. For the quarter ended December 31, 2003, the market price condition was satisfied. As a result, the debentures will be convertible, at the option of the holder, at any time during the quarter ending March 31, 2004. When dilutive, the debentures are considered common stock equivalents and will be included in the calculation of weighted average common shares outstanding on a diluted basis for the first quarter of 2004.

The Company used the net proceeds of the offering to repay the $39.0 million outstanding under the then existing credit facility and to contribute $35.0 million to Sierra Military Health Services, Inc. ("SMHS"). The Company also used $19.9 million of the proceeds to purchase 1.6 million shares of the Company's common stock under its repurchase program. The remainder of the net proceeds were used for working capital and general corporate purposes including additional share repurchases.

Revolving Credit Facility.

On March 3, 2003, the Company entered into a new $65.0 million revolving credit facility, which replaced 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 was initially LIBOR plus 2.25% and is currently LIBOR plus 2.00%. 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 Company has not yet utilized this facility.

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 Company's 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 the Company and those of its 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) other than cash and cash equivalents, subject, in each case, to the exclusion of the capital stock of CII or any of its subsidiaries and certain other exclusions.

The new revolving credit facility has covenants that limit the Company's ability and the ability of the Company's subsidiaries to dispose of assets, incur indebtedness, incur other liens, make investments, loans or advances, make acquisitions, engage in mergers or consolidations, repurchase Company common stock or make capital expenditures and otherwise restricts certain corporate activities. In addition, the Company is required to comply with specified financial ratios as set forth in the new credit agreement. The Company believes it is in compliance with all covenants of the new credit agreement.

Other.

The Company has obligations under capital leases with interest rates from 6.6% to 12.2%. In

addition, the Company has term loans with the City of Baltimore and the State of Maryland with interest rates of up to 3.0%. If SMHS does not meet the employment requirements of the term loans as of December 31, 2004, the term loans will be required to be repaid on December 31, 2004.

Scheduled maturities of the Company's long-term debt and future minimum payments under capital leases, together with the present value of the net minimum lease payments at December 31, 2003, are as follows:

	Long-Term Debt	Obligations Under Capital Leases
	(In thousands)	
Years ending December 31,		
2004	$ 80	$ 117
2005	80	72
2006	82	72
2007	611	67
2008	339	34
Thereafter	115,265	123
Total	$ 116,457	485
Less: Amounts Representing Interest		(134)
Present Value of Minimum Lease Payments		$ 351

The fair value of long-term debt, including the current portion, is estimated to be approximately $116.8 million based on the borrowing rates currently available to the Company.

7.

SHARE REPURCHASE PROGRAM

As of December 31, 2003, the Company's Board of Directors had authorized a program for the repurchase of up to 7.6 million shares of the Company's common stock. Through December 31, 2003, the Company had purchased, at

prevailing prices in the open market by block purchase or private transactions, 5.3 million shares for $99.5 million. As of December 31, 2003, the Company had Board authorization to purchase approximately 2.3 million shares of its common stock.

The Company's new revolving credit facility, as amended, allows for additional stock repurchases of up to $60 million during the remainder of 2004. As of March 1, 2004, the Company has repurchased an additional 708,000 shares for $22.6 million.

8.

INCOME TAXES

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

	2003	2002	
		(In thousands)	
Provision (Benefit) for Income Taxes:			
Current	$ 2,909	$ (11,498)	$
Deferred	41,656	33,586	
Total	$ 44,565	$ 22,088	$

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

	2003	2002	
Statutory Rate	35 %	35 %	
State Income Taxes	--	--	
Tax Preferred Investments	(1)	(1)	
Change in Valuation Allowance	--	(3)	
Intangible Amortization	--	--	
Compensation and Benefit Plans	--	3	
Other	1	--	
Provision for Income Taxes	35 %	34 %	

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

	2003	2002
Deferred Tax Assets:	(In thousands)	
Medical Claims Payable and Losses and Loss Adjustment Expense Reserves	$ 19,165	$ 15,611
Accruals Not Currently Deductible	4,583	16,125
Compensation Accruals	12,619	11,259
Bad Debt Allowances	2,780	3,140

Loss Carryforwards and Credits	18,782	28,696
Depreciation and Amortization	--	3,642
Unearned Premiums	2,772	2,976
Deferred Reinsurance Gains	1,647	1,806
Unrealized Investment Losses (Gains)	257	(777)
Other	105	844
Total	62,710	83,322
Deferred Tax Liabilities:		
Deferred Policy Acquisition Costs	479	758
Depreciation	3,211	--
Other	1,682	242
Total	5,372	1,000
Net Deferred Tax Asset	$ 57,338	$ 82,322

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

	2003	2002
	(In thousands)	
Deferred Tax Assets:		
Medical Claims Payable	$ 7,236	$ 4,587
Accruals Not Currently Deductible	4,688	15,162
Compensation Accruals	12,217	10,772
Bad Debt Allowances	2,428	2,769
Loss Carryforwards and Credits	18,249	28,544
Unrealized Investment Losses (Gains)	195	(353)
Depreciation and Amortization	--	3,650
Other	196	218
Total	45,209	65,349
Deferred Tax Liabilities:		
Depreciation and Amortization	3,099	--
Other	995	849
Total	4,094	849
Net Deferred Tax Asset	$ 41,115	$ 64,500

At December 31, 2003, the Company had approximately $41.9 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 $3.4 million, 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, 2003 or 2002. Under the Company's tax sharing agreements, the discontinued operations do have a valuation allowance at December 31, 2003 and 2002, which is eliminated in the Company's consolidated financial

statements.

Current income tax receivables, including discontinued operations, total $10.0 million at December 31, 2003 and $2.3 million at December 31, 2002.

9. 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 2001. 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 following are the assets and liabilities of the discontinued Texas HMO health care operations:

	December 31,	
	2003	2002
	(In thousands)	
ASSETS		
Cash and Cash Equivalents	$ 47	$ --
Investments	4,048	4,263
Other Assets	115	916
Property and Equipment, Net	--	11,967
TOTAL ASSETS	4,210	17,146
LIABILITIES		
Accounts Payable and Other Liabilities	2,658	9,059
Medical Claims Payable	202	1,754
Mortgage Loan	--	14,961
TOTAL LIABILITIES	2,860	25,774
NET ASSETS (LIABILITIES) OF DISCONTINUED OPERATIONS	$ 1,350	$ (8,628)

The assets and liabilities above do not include an intercompany liability of $6.9 million and $38.4 million from Texas Health Choice, L.C., ("TXHC") to Sierra at December 31, 2003 and 2002, respectively. The liability has been eliminated upon consolidation.

Property and equipment consisted 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 recorded an asset impairment charge of $27.0 million. The real estate was encumbered by a mortgage loan payable to Kaiser-Texas, which was guaranteed by Sierra. In December 2001, the mortgage loan was restructured and 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 accordance with accounting principles generally accepted in the United States of America, the carrying

amount of the mortgage loan was equal to the total future cash payments (interest and principal).

During 2002, TXHC sold four of the eight real estate properties and a parcel of land. 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.

During the second quarter of 2003, a final payment of $12.9 million was made to pay off Kaiser-Texas mortgage loan, resulting in a gain, net of tax, of $1.3 million. During 2003, TXHC sold the four remaining real estate properties for a net loss of $400,000.

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

	Years ended December		
	2003	2002	
	(In thousands)		
Operating Revenues	$ 217	$ 4,791	$ 1
Medical Expenses	(1,802)	(8,933)	1
General and Administrative Expenses	624	1,906	
Asset Impairment, Restructuring, Reorganization and Other Costs	--	5,000	
Interest Expense and Other, Net	(3,399)	(6,216)	
Income (Loss) from Discontinued Operations Before Income Tax	4,794	13,034	(
Income Tax (Provision) Benefit	(1,703)	(4,562)	
Income (Loss) from Discontinued Operations	$ 3,091	$ 8,472	$ (

Operating revenues of $217,000, $153,000 and $153,000 for the years ended December 31, 2003, 2002 and 2001, respectively, are related to investment income. All of the discontinued Texas HMO health care operations had previously been a component of the "managed care and corporate operations" segment.

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.

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.

During 2002, the Company had favorable development related to its medical claims and reduced its medical claims payable and medical expenses by $9.8 million. The favorable development was partially offset by an increase in the

estimate of legal, restitution and other exit related costs of $800,000. The adjustments resulted in income, net of tax, of $5.9 million.

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 for our former members health care claims.

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	Tota
			(In thousands)		
Balance, January 1, 2001.....	$ --	$ 3,755	$ 9,278	$ 800	$ 13,8
Charges recorded.....	1,600	4,380	570	--	6,5
Cash used.....	--	(3,716)	(1,478)	(800)	(5,9
Noncash activity.....	(1,600)	(125)	--	--	(1,7
Changes in estimate.....	--	--	(7,800)	--	(7,8
Balance, December 31, 2001.....	--	4,294	570	--	4,8
Charges recorded.....	--	--	--	--	
Cash used.....	--	(2,490)	(570)	--	(3,0
Noncash activity.....	--	(4,222)	--	--	(4,2
Changes in estimate.....	--	5,000	--	--	5,0
Balance, December 31, 2002.....	--	2,582	--	--	2,5
Charges recorded.....	--	--	--	--	
Cash used.....	--	(909)	--	--	(9
Noncash activity.....	--	(523)	--	--	(5
Changes in estimate.....	--	(1,150)	--	--	(1,1
Balance, December 31, 2003.....	$ --	$ --	$ --	$ --	$

10. CII FINANCIAL, INC. DISCONTINUED OPERATIONS

On January 15, 2003, the Company announced that it was exploring strategic alternatives for its workers' compensation company, CII Financial Inc., ("CII"). Sierra's Board of Directors approved the sale of the operations on December 31, 2002. Accordingly, beginning in the fourth quarter of 2002, the Company reclassified its workers' compensation insurance business as discontinued operations.

In conjunction with the decision to sell the workers' compensation operations at the end of 2002, 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.

In the second quarter of 2003, CII recorded $4.0 million, $2.6 million after tax, in additional valuation adjustments. On November 25, 2003, the Company announced that it had reached an agreement to sell Cal Indemnity and its subsidiaries. Cal Indemnity is a wholly-owned subsidiary of CII and is CII's only significant asset. As part of the

purchase agreement, Cal Indemnity and its subsidiaries have stopped voluntarily issuing new or renewal policies except in Nevada. The buyer intends to place Cal Indemnity and its subsidiaries in run-off. An independent third party claims administrator has been engaged to administer the claims when the transaction is consummated. The transaction was initially valued at $79.5 million, consisting of $15.5 million payable at closing and a contingent payment of $64.0 million, which will be payable in 2010. The cash payable at closing is subject to certain adjustments and the contingent payment can be increased or decreased based upon favorable or adverse loss and allocated loss

adjustment expense development from closing through December 2009. The Company currently estimated that the adjustments would reduce the net sales proceeds to approximately $73 million. In the fourth quarter of 2003, the Company recorded a charge of $15.6 million, gross and net of tax, to write down the investment in Cal Indemnity to its estimated net sales proceeds. The Company did not recognize a tax benefit on the charge since the Company's tax basis was less than our investment in Cal Indemnity. The sale is subject to regulatory approvals and is expected to close by April 30, 2004.

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 also 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,	
	2003	2002

	(In thousands)	
ASSETS		
Cash and Cash Equivalents	$ 58,634	$ 23,060
Investments	243,647	287,242
Reinsurance Recoverable	177,333	189,409
Property and Equipment, Net	1,612	2,167
Other Assets	48,320	46,034
TOTAL ASSETS	529,546	547,912
LIABILITIES		
Accounts Payable and Other Accrued Expenses	54,208	30,989
Senior Debentures	--	16,765
Reserve for Loss and Loss Adjustment Expenses	415,339	427,192
TOTAL LIABILITIES	469,547	474,946
NET ASSETS OF DISCONTINUED OPERATIONS	$ 59,999	$ 72,966

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

	Years ended December 31,		
	2003	2002	2001
OPERATING REVENUES:	(In thousands)		
Specialty Product Revenues	$ 123,001	$ 176,189	$ 173,215
Investment and Other Revenues	9,301	12,633	14,786
Total Revenues	132,302	188,822	188,001
OPERATING EXPENSES:			
Specialty Product Expenses	145,824	209,601	183,666
Asset Impairment	15,610	--	--
Interest Expense and Other, Net	(968)	1,059	707
Total Expenses	160,466	210,660	184,373
(Loss) Income from Discontinued Operations Before Income Tax	(28,164)	(21,838)	3,628
Income Tax Benefit (Provision)	5,281	7,506	(1,643)
Net (Loss) Income from Discontinued Operations	$ (22,883)	$ (14,332)	$ 1,985

All of the discontinued operations of CII were a component of the "workers' compensation operations" segment for the year ended December 31, 2001.

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

	2003	2002
	(In thousands)	
Land	$ 116	$ 116
Buildings and Improvements	1,535	1,522
Furniture, Fixtures and Equipment	1	70
Data Processing Equipment and Software	20	3,534
Software in Development and Construction in Progress	--	45
Less: Accumulated Depreciation	(60)	(3,120)
Property and Equipment, Net	$ 1,612	$ 2,167

The following table summarizes the investments of CII as of December 31, 2003:

	Amortized Cost	Gross Unrealized Gains	G Unr L
Available-for-Sale Investments:		(In thousa	
Classified as Current:			
U.S. Government and its Agencies	$ 95,419	$ 440	$
Municipal Obligations	123,439	702	
Corporate Bonds	3,688	60	
Total Current	222,546	1,202	
Classified as Restricted:			
U.S. Government and its Agencies	12,888	264	
Municipal Obligations	4,240	212	
Other	533	--	
Total Debt Securities	17,661	476	
Preferred Stock	75	--	
Total Restricted	17,736	476	
Total Available-for-Sale	$ 240,282	$ 1,678	$
Held-to-Maturity Investments:			
Classified as Current:			
U.S. Government and its Agencies	$ 1,748	$ 25	$
Classified as Long-term:			
Municipal Obligations	328	18	
Classified as Restricted:			
Municipal Obligations	638	34	
Corporate Bonds	500	11	
Other	325	--	
Total Restricted	1,463	45	
Total Held-to-Maturity	$ 3,539	$ 88	$

The fair value of investments with unrealized losses is $111.1 million. The fair value of investments with unrealized losses for more than 12 months is $2.6 million with current unrealized losses that total $20,000. CII has not experienced any investment impairments that were considered other than temporary.

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

	Amortized Cost	Gross Unrealized Gains	G Unr L
		(In thousa	
Available-for-Sale Investments:			
Classified as Current:			
U.S. Government and its Agencies	$ 163,384	$ 2,682	$
Municipal Obligations	65,454	338	
Corporate Bonds	19,830	49	
Mortgage Backed Securities	1,020	47	
Other	10,987	46	
Total Debt Securities	260,675	3,162	
Preferred Stock	5,939	210	
Total Current	266,614	3,372	
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	$
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 contractual maturities of available-for-sale debt securities at December 31, 2003 are shown below:

	Amortized Cost	Fair Value
	(In thousands)	
Due in one year or less	$ 11,722	$ 11,907
Due after one year through five years	137,705	138,088
Due after five years through ten years	63,650	63,435
Due after ten years through fifteen years	12,806	12,976
Due after fifteen years	14,324	13,627
Total	$ 240,207	$ 240,033

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, 2003 are shown below:

	Amortized Cost	Fair Value
	(In thousands)	
Due in one year or less	$ 2,549	$ 2,585
Due after one year through five years	25	25
Due after five years through ten years	--	--
Due after ten years through fifteen years	965	1,017
Due after fifteen years	--	--
Total	$ 3,539	$ 3,627

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 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 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, $1.2 million and $3.0 million in 2003, 2002 and 2001, respectively. For the years ended December 31, 2003, 2002 and 2001, CII amortized deferred gains of $1.7 million, $1.9 million and $2.7 million, respectively. Such amortization is included as a credit to specialty product expense on the accompanying condensed consolidated statements of operations.

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, have reduced coverage limits and exclusions for terrorist acts. The Company continues to retain the first $500,000 per occurrence but the maximum coverage has been reduced from statutory limits (i.e., unlimited) to $20.0 million per occurrence. The Company also must meet certain annual aggregate deductibles before it can begin to recover from some of its reinsurers. This new coverage will result in the Company retaining more of the losses and 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 the A.M. Best Company as of December 31, 2003.

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, 2003 and 2002, the amount of reinsurance recoverable under prospective reinsurance contracts for unpaid loss and LAE was $159.9 million and $169.0 million, respectively. At December 31, 2003 and 2002, the amount of reinsurance recoverable under the retroactive reinsurance contract was $5.3 million and $6.9 million, respectively. The amount of reinsurance receivable for paid loss and LAE was $12.1 million and $13.5 million at December 31, 2003 and 2002, 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, 2003:

	Recoveries on Paid Losses/LAE	Change in Recoverable on Unpaid Losses/LAE	Pr C
		(In thousands)	
Year Ended December 31, 2003:			
Low level reinsurance carrier	$ 43,818	$ (19,827)	$
Excess of loss reinsurance carriers	6,544	10,698	
Total	$ 50,362	$ (9,129)	$
Year Ended December 31, 2002:			
Low level reinsurance carrier	$ 60,314	$ (37,854)	$
Excess of loss reinsurance carriers	2,308	19,403	
Total	$ 62,622	$ (18,451)	$
Year Ended December 31, 2001:			
Low level reinsurance carrier	$ 80,932	$ (40,430)	$
Excess of loss reinsurance carriers	4,407	9,125	
Total	$ 85,339	$ (31,305)	$

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 the period when the change occurs.

	Years Ended December		
	2003	2002	
		(In thousands)	
Net Beginning Losses and LAE Reserve	$ 258,190	$ 198,252	$ 1
Net Provision for Insured Events Incurred in:			
Current Year	88,819	139,513	1
Prior Years	16,877	23,998	
Total Net Provision	105,696	163,511	1
Net Payments for Losses and LAE Attributable to Insured Events Incurred in:			
Current Year	16,236	29,448	
Prior Years	92,183	74,125	

Total Net Payments	108,419	103,573	
Net Ending Losses and LAE Reserve	255,467	258,190	1
Reinsurance Recoverable	159,872	169,002	1
Gross Ending Losses and LAE Reserve	$ 415,339	$ 427,192	$ 3

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, 2003, 2002 and 2001, the Company experienced prior year net adverse loss development of $16.9 million, $24.0 million and $8.7 million, respectively. The net adverse

loss development recorded was largely attributable to higher costs per claim, or claim severity, in California. 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 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 commenced an offer to exchange the subordinated debentures for cash and/or new debentures. On May 7, 2001, CII closed its exchange offer on $42.1 million of its outstanding subordinated debentures. CII 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 subsequent cash payments, including interest, related to the debentures were reductions of the carrying amount of the debentures and no additional interest expense was recognized.

On June 3, 2003, CII called the outstanding 9½% senior debentures and redeemed them at the applicable premium of 102.5% along with all outstanding accrued interest. The transaction resulted in a gain of $1.4 million, or $1.3 million net of tax.

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 9.5% under which principal and interest are due on demand.

Also in connection with the exchange offer for the subordinated debentures, Cal Indemnity, a wholly-owned subsidiary of CII, 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.

In connection with the redemption of the outstanding 9½% senior debentures on June 3, 2003, CII entered into a promissory note payable to another unregulated subsidiary of Sierra aggregating $15.6 million. The loan bears interest at 7.5%, which is due semi-annually on March 15 and September 15 of each year, commencing September 15, 2003. The note is payable on demand after September 15, 2004. All intercompany notes receivable/payable have been eliminated upon consolidation.

11. 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)**
2004	$ 21,384
2005	20,402
2006	19,769
2007	19,080
2008	17,328
Thereafter	117,471
Total	$ 215,434

Rent expense totaled $20.6 million, $15.8 million and $7.9 million for the years ended December 31, 2003, 2002 and 2001, respectively.

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 amount or range of any potential loss cannot be reasonably estimated but the ultimate resolution of these pending legal proceedings should not have a material adverse effect on our financial condition.

12. RELATED PARTY TRANSACTIONS

At December 31, 2002, the Company's Chief Executive Officer ("CEO") had loans outstanding to the Company in the amount of $4.2 million with a maturity date of December 31, 2003. During 2003, the Company's CEO paid the entire outstanding balance including accrued interest.

The Company has a minority interest in a health care facility in Las Vegas, which is accounted for under the equity method. The Company made an initial capital contribution of $1.1 million and has subsequently increased the carrying amount of its investment by $2.9 million to reflect its share of the undistributed income of the health care facility. The Company made capitated payments of $26.7 million, $24.3 million and $21.2 million to the health care facility for services performed in the ordinary course of business during 2003, 2002 and 2001, respectively.

On February 11, 2004, the Company purchased 500,000 shares at $32.00 per share from its CEO for a total of $16.0 million. The closing price of the Company's common stock on February 11, 2004 was

$32.35. The shares are included in the total repurchases through March 1, 2004, of 708,000. The purchase was approved by the Company's Board of Directors.

The Company incurred legal fees of $25,000, $24,000 and $38,000 in the years ended December 31, 2003, 2002 and 2001 respectively, with a Nevada law firm of which a non-employee Board of Director member is a shareholder.

13. MEDICAL CLAIMS PAYABLE

The following table reconciles the beginning and ending balances of medical claims payable:

	Years Ended December 31,		
	2003	2002	2001
	(In thousands)		
Medical Claims Payable, Beginning of the Period	$ 98,031	$ 81,662	$ 74,40
Add: Components of Incurred Medical Expenses			
Current Period Medical Claims	776,857	723,167	616,26
Changes in Prior Periods' Estimates	(13,992)	(10,877)	(7,51
Total Incurred Medical Expenses	762,865	712,290	608,75
Less: Medical Claims Paid			
Current Period	683,597	630,411	541,07
Prior Period	73,550	65,510	60,42
Total Claims Paid	757,147	695,921	601,49
Medical Claims Payable, End of Period	$ 103,749	$ 98,031	$ 81,66

Amounts incurred related to prior years show that the liability at the beginning of each year was ultimately greater than the amount subsequently incurred. This favorable development has primarily been a result of claims being settled for amounts less than originally estimated.

14. MILITARY MEDICAL CLAIMS PAYABLE

The following table reconciles the beginning and ending balances of military medical claims payable:

	Years Ended December 31,		
	2003	2002	2001
	(In thousands)		
Military Health Care Payable, Beginning of the Period...	$ 65,223	$ 77,261	$ 84,85
Add: Components of Incurred Medical Expenses			
Current Period Medical Claims.....	318,833	251,632	219,56
Changes in Prior Periods' Estimates			
Earnings Related Changes.....	(3,235)	(4,601)	2,08
Non-Earnings Related Changes.....	(10,777)	(16,509)	(11,89
Total Incurred Medical Expenses.....	304,821	230,522	209,76
Less: Military Contract Claims Paid			
Current Period.....	244,644	194,659	158,97
Prior Period.....	48,795	47,901	58,38
Total Military Contract Claims Paid.....	293,439	242,560	217,35
Military Health Care Payable, End of Period.....	$ 76,605	$ 65,223	$ 77,26

The military contract expenses presented in the Consolidated Statements of Operations include the total incurred medical expenses presented above and the general and administrative expenses for SMHS. SMHS' general and administrative expenses under the military contract totaled $147.7 million, $129.9 million and $121.9 million for the years ended December 31, 2003, 2002, and 2001, respectively. Total incurred medical expenses include the current year expenses plus adjustments to prior periods' estimates. Any subsequent change in an estimate for a prior period is reflected in the current year. Certain adjustments to prior periods have a current year earnings impact while other adjustments do not have a current year earnings impact. The adjustments that do not have a current year earnings impact are the result of an offsetting revenue adjustment in accordance with SMHS' risk-sharing terms under SMHS' contract with the Department of Defense ("DoD"). For example in 2003, SMHS had total adjustments to prior period estimates of $14.0 million. These adjustments resulted in a reduction of current period expense of $14.0 million and current period revenue of $10.8 million for a pre-tax increase of $3.2 million to current period earnings. The favorable development in the earnings related changes for the years ended December 31, 2003 and 2002 have primarily been a result of claims being settled for amounts less than originally estimated.

15. 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 $5.3 million, $4.4 million and $4.8 million for the years ended December 31, 2003, 2002 and 2001, 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. No premiums have been paid under these policies since July 2002.

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. The Company expects to contribute approximately $800,000 to the plan in 2004 to fund expected benefit payments. The plan measurement date was December 31, 2003.

A reconciliation of ending year SERP balances is as follows:

	Years ended December 31,		
	2003	2002	2
		(In thousands)	
Change in benefit obligation			
Benefit obligation at beginning of year	$ 23,461	$ 19,143	$ 13
Service cost	374	292	
Interest cost	1,547	1,375	1
Actuarial loss	5,298	3,435	4
Expected benefits paid	(784)	(784)	
Benefit obligation at end of year	$ 29,896	$ 23,461	$ 19
Change in plan assets			
Fair value of plan assets at beginning of year	$ --	$ --	$
Employer contributions	784	784	
Expected benefits paid	(784)	(784)	
Fair values of plan assets at end of year	$ --	$ --	$
Funded status	$ (29,896)	$ (23,461)	$(19
Unrecognized prior service cost	8,145	6,761	3
Unrecognized net actuarial loss	8,212	5,640	6

Accrued net benefit cost	(13,539)	(11,060)	(8
Unfunded accumulated benefit obligation	(21,146)	(18,330)	(16
Additional Minimum Liability	(7,607)	(7,270)	(7
Intangible Asset	7,607	5,640	7
Accumulated Other Comprehensive Loss	--	(1,630)	
Benefit liability	$ (21,146)	$ (18,330)	$(16
Assumptions:			
Discount Rate	5.8%	6.5%	
Rate of Compensation Increase	3.0%	3.0%	
Components of Net Periodic Benefit Cost:			
Service Cost	$ 374	$ 292	$
Interest Cost	1,547	1,375	1
Amortization of Prior Service Credits	1,210	925	
Recognized Actuarial Loss	131	575	
Net Periodic Benefit Cost	$ 3,262	$ 3,167	$ 2

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 $14.7 million, $11.7 million and $10.3 million at December 31, 2003, 2002 and 2001, respectively.

16. 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. A committee appointed by the Board of Directors grants awards. 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	Options Exercisable	Opt Pr
		(Number of shares i	
Outstanding January 1, 2001	4,250	674	$ 3.13
Granted	2,218		4.24
Exercised	(72)		3.75
Canceled	(393)		3.19
Outstanding December 31, 2001	6,003	1,391	3.13
Granted	944		8.13
Exercised	(995)		3.25
Canceled	(100)		3.25
Outstanding December 31, 2002	5,852	1,866	3.13
Granted	1,603		12.21
Exercised	(1,918)		3.25
Canceled	(178)		3.75
Outstanding December 31, 2003	5,359	1,384	3.13
Available for Grant at December 31, 2003	2,021		

The following table summarizes information about stock options outstanding at December 31, 2003:

Range of Exercise Price	Weighted Average Contractual Life Remaining in Days	Options		Weighted Average Exercise Price	
		Outstanding	Exercisable	Outstanding	Exercisable
$3.13 - 4.80	2,362	1,190	262	$ 3.80	$ 3.76
5.73 - 8.82	2,022	1,186	491	6.88	6.72
8.93 - 12.21	3,148	1,440	498	10.67	10.10
12.61 - 23.96	3,003	1,543	133	15.34	21.06

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 2003, a total of 574,000 shares were purchased at prices of $10.21 and $10.38 per share. At December 31, 2003, the Company had 191,000 shares reserved for purchase under the Purchase Plan of which 119,000 shares were purchased by employees at $16.28 per share in January 2004.

Restricted Stock Units.

The Company issued 244,000 restricted stock units ("units"), to certain executives during 2001. The first half of the units vested 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 unvested 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 $451,000, $585,000 and $342,000 for 2003, 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 2003, 2002 and 2001, respectively: dividend yield of 0% for all years; expected volatility of 73%, 74% and 83%; risk-free interest rates of 2.93%, 3.32% and 4.34%; and expected lives of two to five years. The weighted average fair value of options granted in 2003, 2002 and 2001 was $10.94, $8.60 and $5.58, 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 2003, 2002 and 2001, respectively: dividend yield of 0% for all years; expected volatility of 64%, 56% and 85%; risk-free interest rates of 0.93%, 1.48% and 4.36%; and expected lives of six months for all years.

17. CONSOLIDATED STATEMENTS OF CASH FLOWS SUPPLEMENTAL INFORMATION

Supplemental statements of cash flows information is presented below:

	Years ended December 31,		
	2003	2002	2001
	(In thousands)		
Cash Paid During the Year for Interest (Net of Amount Capitalized)	$ 3,342	$ 7,205	$ 17,164
Cash (Paid) Received During the Year for Income Taxes	(10,741)	12,796	221
Non-cash Investing and Financing Activities:			
Retired Sale-Leaseback Assets, Liabilities and Financing Obligations	--	89,751	14,552
Stock Issued for Exercise of Options and Related Tax Benefits	12,596	6,837	97
Additions to Capital Leases	153	--	--
Debentures Exchanged	--	--	19,692

18. ASSET IMPAIRMENT, RESTRUCTURING, REORGANIZATION AND OTHER COSTS

The table below presents a summary of asset impairment, restructuring, reorganization and other cost activity for the periods indicated that were included in general and administrative expenses. Discontinued operations are excluded from this presentation.

	Restructuring and

	Reorganization	Other	Total
	(In thousands)		
Balance, January 1, 2001	$ 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
Charges recorded	--	--	--
Cash used	--	--	--
Noncash activity	--	--	--
Changes in estimate	--	--	--
Balance, December 31, 2003	$ --	$ 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, 2003, are appropriate and that no revisions to the estimates are necessary at this time.

19. 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 managed care federal contract for the Department of Defense's TRICARE program in Region 1.

SMHS completed the fifth year of a five-year contract in May 2003 and is in the first year of a contract extension. In August 2002, the DoD requested proposals for managed care services under the Next Generation TRICARE ("T-Nex") contract. The Company submitted its proposal in January 2003 for the T-Nex North Region contract, which includes Region 1, as well as Michigan, Ohio, Kentucky, Indiana, Illinois, Wisconsin, Virginia and North Carolina. However, in August 2003, the DoD awarded the T-Nex North Region contract to a competitor and the General Accounting Office denied the Company's protest of the award in December 2003. The new contractor is scheduled to be operational in Region 1 on September 1, 2004 and the new contract will supersede the remainder of the Company's current TRICARE Region 1 contract. After the new contractor is operational on September 1, 2004, SMHS will commence a six-month phase-out of operations at prices previously negotiated with the DoD. SMHS does not meet the definition of discontinued operations since the Company does not have plans to dispose of the operations before the phase-out is complete.

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.

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, 2003			
Medical Premiums	$ 962,176	$ --	$ 962,176
Military Contract Revenues	--	465,313	465,313
Professional Fees	37,367	--	37,367
Investment and Other Revenues	18,192	2,031	20,223
Total Revenue	$1,017,735	$ 467,344	$1,485,079
Segment Operating Profit	$ 117,607	$ 14,790	$ 132,397
Interest Expense	(5,217)	(274)	(5,491)
Other Income (Expense), Net	(631)	408	(223)
Income from Continuing Operations Before Income Taxes	$ 111,759	$ 14,924	$ 126,683
Segment Assets	$ 424,695	$ 175,670	$ 600,365
Capital Expenditures	(19,768)	(2,006)	(21,774)
Depreciation and Amortization	14,234	1,695	15,929
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	(7,455)	(195)	(7,650)
Other Income (Expense), Net	(309)	364	55
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	(15,578)	(160)	(15,738)

Other Income (Expense), Net	(2,290)	171	(2,119)
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

(1) Goodwill amortization of $805,000 is included as part of the managed care and corporate operations segment for 2001.

20. 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, 2003, is $14.8 million. The Company has determined that the recorded goodwill is 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, 2001:

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

21. UNAUDITED QUARTERLY INFORMATION

Quarter Ended 2003:	March 31	June 30	September 30
	(In thousands, except per shar		
Operating Revenues	$ 352,270	$ 370,205	$ 389,237
Operating Income from Continuing Operations	25,275	33,296	35,178
Net Income from Continuing Operations	15,428	20,510	22,177
Net Income	15,022	20,265	22,207
Basic Earnings per Share:			
Income from Continuing Operations	$ 0.53	$ 0.75	$ 0.78
Net Income	0.52	0.74	0.78
Diluted Earnings per Share:			
Income from Continuing Operations	$ 0.50	$ 0.68	$ 0.72
Net Income	0.49	0.67	0.72
Quarter Ended 2002:			
Operating Revenues	$ 303,748	$ 316,968	$ 331,017
Operating Income from Continuing Operations	13,513	17,808	21,025
Net 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	$ 0.25	$ 0.37	$ 0.42
Net Income	0.26	0.37	0.48
Diluted Earnings per Share:			
Income from Continuing Operations	$ 0.24	$ 0.34	$ 0.39
Net Income	0.25	0.34	0.44

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

None.

ITEM 9a. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

The Company's management, with the participation of the Company's Chief Executive Officer and Chief Financial

Officer, evaluated the effectiveness of the Company's disclosure controls and procedures as of the end of the period covered by this report. Based on that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that the Company's disclosure controls and procedures as of the end of the period covered by this report were designed and were functioning effectively to provide reasonable assurance that the information required to be disclosed by the Company in reports filed under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms. The Company believes that a system of controls, no matter how well designed and operated, cannot provide absolute assurance that the objectives of the controls 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.

Change in Internal Control over Financial Reporting

No change in the Company's internal control over financial reporting occurred during the Company's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

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 2004 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 2004 Annual Meeting of Stockholders, is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information set forth under the caption "Security Ownership of Certain Beneficial Owners and Management" in Sierra's Proxy Statement for its 2004 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 2004 Annual Meeting of Stockholders, is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information set forth under the caption "Principal Accounting Fees and Services" in Sierra's Proxy Statement for its 2004 Annual Meeting of Stockholders, is incorporated herein by reference.

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:

	Page
Independent Auditors' Report	58
Consolidated Balance Sheets at December 31, 2003 and 2002	59
Consolidated Statements of Operations for the Years Ended December 31, 2003, 2002 and 2001	60
Consolidated Statements of Stockholders' Equity for the Years Ended December 31, 2003, 2002 and 2001	61
Consolidated Statements of Cash Flows for the Years Ended December 31, 2003, 2002 and 2001	62
Notes to Consolidated Financial Statements	63

(a)(2) Financial Statement Schedules:

Schedule I	- Condensed Financial Information of Registrant	S-1
Schedule V	- Supplemental Information Concerning Property-Casualty Insurance	S-5
Other Information:		
Section 403.04 b	- Exhibit of Redundancies (Deficiencies)	S-6

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, as amended through September 10, 2003.

(3.2) 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.

(3.3) 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.

(3.4) 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.

(3.5) 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) 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, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2002.

(10.3) First Amendment to the 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.

(10.4) Second Amendment to the 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.

(10.5) Compensatory Plans, Contracts and Arrangements.

(1) Employment Agreement with Jonathon W. Bunker dated February 1, 2003, incorporated by reference to Exhibit 10.6 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2002.

(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 February 12, 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, incorporated by reference to Exhibit 10.6 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2002.

(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, 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, incorporated by reference to Exhibit 10.6 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2002.

(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 for the year ended December 31, 2003.

(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.

(10.6) Stock Purchase Agreement, dated as of November 25, 2003, as amended on December 17, 2003, as further amended on December 29, 2003 and as further amended on January 12, 2004, among Sierra Health Services, Inc., CII Financial, Inc. and Folksamerica Holding Company, Inc.

(10.7)

Form of Contingent Purchase Price Note Agreement among Folksamerica Holding Company, Inc., Sierra Health Services, Inc., CII Financial, Inc., and, with respect to Article 5 only, Folksamerica Reinsurance Company.

(12.1) Statement re Computation of Ratios.

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

(23.1) Consent of Deloitte & Touche LLP

(31.1) Rule 13a - 14(a) Certification of Chief Executive Officer.

(31.2) Rule 13a - 14(a) Certification of Chief Financial Officer.

(32.1) 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 March 5, 2004.

(32.2) 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 March 5, 2004.

All other Exhibits are omitted because they are not applicable.

(b) Reports on Form 8-K

Current Report on Form 8-K, dated October 22, 2003, with the Securities and Exchange Commission reporting operating results for the quarter ended September 30, 2003.

Current Report on Form 8-K, dated October 28, 2003, with the Securities and Exchange Commission announcing an increase in the Company's share repurchase program.

Current Report on Form 8-K, filed November 26, 2003, with the Securities and Exchange Commission in connection with the announcement of the Company hosting a conference for research analysts and institutional investors on December 2, 2003.

Current Report on Form 8-K, filed November 26, 2003, with the Securities and Exchange Commission in connection with the announcement that the Company and its wholly-owned subsidiary CII Financial Inc., entered into a Stock Purchase Agreement with Folksamerica Holding

Company, Inc. which provides for the sale to the Purchaser of all of the capital stock of California Indemnity Insurance Company ("CIIC"), a wholly-owned subsidiary of CII Financial Inc.

Current Report on Form 8-K, dated December 8, 2003, with the Securities and Exchange Commission announcing that the United States General Accounting Office had denied the Company's protest of the August 2003 award of Managed Care Support Services Contracts by the United States Department of Defense.

Current Report on Form 8-K, dated December 17, 2003, with the Securities and Exchange Commission announcing that under the terms of the offering memorandum of its 2¼% senior convertible debentures due 2023, each holder of the debentures will have the right to convert them into shares of Sierra's common stock during the first quarter of 2004.

(d) Financial Statement Schedules

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

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 5, 2004

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 5, 2004
/s/ Paul H. Palmer Paul H. Palmer	Senior Vice President of Finance, Chief Financial Officer, and Treasurer (Chief Accounting Officer)	March 5, 2004
/s/ Erin E. MacDonald Erin E. MacDonald	Director	March 5, 2004
/s/ Charles L. Ruthe Charles L. Ruthe	Director	March 5, 2004
/s/ William J. Raggio William J. Raggio	Director	March 5, 2004
/s/ Thomas Y. Hartley Thomas Y. Hartley	Director	March 5, 2004
/s/ Albert L. Greene Albert L. Greene	Director	March 5, 2004
/s/ Michael E. Luce Michael E. Luce	Director	March 5, 2004
/s/ Anthony L. Watson Anthony L. Watson	Director	March 5, 2004

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

Decem

	2003
	(In th
ASSETS	
CURRENT ASSETS:	
Cash and Cash Equivalents	$ 2,515
Short-term Investments	994
Current Portion of Deferred Tax Asset	27,612
Prepaid Expenses and Other Current Assets	40,823
Total Current Assets	71,944
PROPERTY AND EQUIPMENT - NET	30,093
EQUITY IN NET ASSETS OF SUBSIDIARIES	181,946
NOTES RECEIVABLE FROM SUBSIDIARIES	9,135
GOODWILL	2,154
DEFERRED TAX ASSET	4,064
OTHER	46,267
TOTAL ASSETS	$ 345,603
LIABILITIES AND STOCKHOLDERS' EQUITY	
CURRENT LIABILITIES:	
Accounts Payable and Other Accrued Liabilities	$ 23,336
Current Portion of Long-term Debt	47
Total Current Liabilities	23,383
LONG-TERM DEBT (Less Current Portion)	115,013
OTHER LIABILITIES	56,443
TOTAL LIABILITIES	194,839
STOCKHOLDERS' EQUITY:	
Capital Stock	166
Treasury Stock	(112,737)
Additional Paid-in Capital	227,417
Deferred Compensation	(22)
Accumulated Other Comprehensive (Loss) Gain	(479)
Retained Earnings (Accumulated Deficit)	36,419
TOTAL STOCKHOLDERS' EQUITY	150,764
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 345,603

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

	Years
	2003
	(
REVENUES:	

Management Fees	$ 123,669
Subsidiary Dividends	11,000
Investment and Other Income	3,179
Total Revenues	137,848
EXPENSES:	
Depreciation	9,052
Other	37,923
Interest Expense and Other, Net	2,682
Total Expenses	49,657
INCOME BEFORE INCOME TAXES	88,191
INCOME TAX PROVISION	(26,543)
INCOME (LOSS) OF PARENT COMPANY	61,648
EQUITY IN UNDISTRIBUTED INCOME OF SUBSIDIARIES FROM CONTINUING OPERATIONS	20,470
INCOME FROM CONTINUING OPERATIONS	82,118
LOSS FROM DISCONTINUED OPERATIONS	(19,792)
NET INCOME	$ 62,326

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

	Years
	2003
	(
CASH FLOWS FROM OPERATING ACTIVITIES:	
Net Income From Continuing Operations	$ 82,118
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:	
Depreciation and Amortization	9,052
Deferred Compensation	451
Loss on Property and Equipment Dispositions	190
Equity in Undistributed Income of Subsidiaries Continuing Operations	20,470
Change in Assets and Liabilities	(88,117)
Net Cash Provided by Operating Activities	24,164
CASH FLOWS FROM INVESTING ACTIVITIES:	
Capital Expenditures	(6,486)
Property and Equipment Dispositions	2,599
Decrease (Increase) in Investments	727
Dividends from Subsidiaries	11,000
Net Cash Provided by Investing Activities	7,840

CASH FLOWS FROM FINANCING ACTIVITIES:	
Proceeds from Long-term Borrowing	115,000
Proceeds of Sale Leaseback Deposit	--
Reductions in Long-term Obligations and Payments on Capital Leases	(60,092)
Debt Issue Costs	(5,834)
Notes Receivable from Subsidiaries	--
Purchase of Treasury Stock	(99,485)
Exercise of Stock in Connection with Stock Plans	19,171
Net Cash Used for by Financing Activities	(31,240)
Net Increase (Decrease) in Cash and Cash Equivalents	764
Cash and Cash Equivalents at Beginning of Year	1,751
Cash and Cash Equivalents at End of Year	$ 2,515
Supplemental condensed statements of cash flows information:	
Cash Paid During the Year for Interest (Net of Amount Capitalized)	$ 3,254
Cash (Paid) Received During the Year for Income Taxes	(10,324)
Noncash Investing and Financing Activities:	
Stock Issued for Exercise of Options and Related Tax Benefits	12,596
Retired Sale-Leaseback Assets, Liabilities and Financing Obligations	--
Addition to capital leases	17

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
SCHEDULE I - CONDENSED FINANCIAL INFORMATION OF REGISTRANT (Continued)
NOTES TO CONDENSED INFORMATION OF REGISTRANT
For the Years Ended December 31, 2003 and 2002

1. LONG-TERM DEBT

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

December 31,	**(In thousand**
2004	$ 47
2005	3
2006	3
2007	4
2008	3
Thereafter	115,000
Total	$ 115,060

2. OTHER

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, 2003.

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, 2003.....	$ 1,424	$ 415,339	$ --	$ 36,847	$ 126,496	$ 10,7
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

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

	Year ended December 31,						
	2003	2002	2001	2000	1999	1998	199
Losses and LAE Reserve.....	$415,339	$427,192	$ 385,705	$ 374,554	$ 244,394	$ 212,264	$202,6
Less Reinsurance Recoverables (1).....	159,872	169,001	187,453	218,757	110,089	37,797	21,0
Net Loss and LAE Reserves.....	255,467	258,191	198,252	155,797	134,305	174,467	181,6
Net Reserve Re-estimated as of:							
1 Year Later.....	--	275,068	222,250	164,488	157,598	184,386	172,0
2 Years Later.....	--	--	230,545	179,043	171,136	204,029	173,5

3 Years Later.....	--	--	--	185,160	183,524	218,626	186,7
4 Years Later.....	--	--	--	--	189,724	231,386	198,4
5 Years Later.....	--	--	--	--	--	237,137	210,7
6 Years Later.....	--	--	--	--	--	--	214,5
7 Years Later.....	--	--	--	--	--	--	
8 Years Later.....	--	--	--	--	--	--	
9 Years Later.....	--	--	--	--	--	--	
10 Years Later.....	--	--	--	--	--	--	
Cumulative (Deficiency) Redundancy.....	--	(16,877)	(32,293)	(29,363)	(55,419)	(62,670)	(32,8
Cumulative Net Paid as of:							
1 Year Later.....	--	92,184	74,125	69,599	61,522	80,416	71,9
2 Years Later.....	--	--	126,057	105,043	103,855	124,191	117,7
3 Years Later.....	--	--	--	128,934	127,505	159,335	143,3
4 Years Later.....	--	--	--	--	144,893	179,825	164,5
5 Years Later.....	--	--	--	--	--	195,834	178,4
6 Years Later.....	--	--	--	--	--	--	188,6
7 Years Later.....	--	--	--	--	--	--	
8 Years Later.....	--	--	--	--	--	--	
9 Years Later.....	--	--	--	--	--	--	
10 Years Later.....	--	--	--	--	--	--	
Net Reserve.....	255,467	258,191	198,252	155,797	134,305	174,467	181,6
Reins. Recoverables.....	159,872	169,001	187,453	218,757	110,089	37,797	21,0
Gross Reserve.....	$415,339	427,192	385,705	374,554	244,394	212,264	202,6
Net Re-estimated Reserve.....		275,068	230,545	185,160	189,724	237,137	214,5
Re-estimated Reins Recoverables.....		209,774	258,176	315,389	203,145	86,987	39,8
Gross Re-estimated Reserve.....		484,842	488,721	500,549	392,869	324,124	254,3
Gross Cumulative (Deficiency) Redundancy.....		$(57,650)	$(103,016)	$(125,995)	$(148,475)	$(111,860)	$(51,6

(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, 2003 and 2002. However, for purposes of the reconciliation and development tables, loss and LAE information are shown net of reinsurance.