

2012

BENEFITS COST & COVERAGE INFORMATION GUIDE

A COMPARISON OF BENEFIT COVERAGE AND COST SUPPLEMENT INFORMATION



FACULTY/STAFF/RESEARCH POST DOCS

This document provides Health Care and Voluntary Benefits cost and coverage information offered to eligible BCM Faculty, Staff, and Research Postdoctoral Appointments.

The following **Core Benefits** are provided to eligible employees at no cost. Additional information about these benefits is located on the BCM Intranet – Human Resources – Benefits – Benefits at a Glance page.

- 401(a) Retirement Plan
- Backup Care
- Basic Accidental Death & Dismemberment Insurance (AD&D)
- Basic Life Insurance
- Bright Horizons Family Solutions
- Business Travel Accident Insurance
- Emeriti Retirement Health Solutions
- Employee Assistance Program (EAP)
- Holiday Pay/Floating Time Off
- Long Term Disability (LTD)
- Sick Pay
- Tuition Assistance
- Vacation Pay

Contact the HR – Benefits Office

BY PHONE: 713-798-1500

BY E-MAIL: ask-insurance@bcm.edu (general) or ask-retirement@bcm.edu (retirement)

IN PERSON: 2450 Holcombe, Ste. OW100, Houston, TX 77021

2012 HEALTH CARE CHOICES & COSTS

Baylor College of Medicine's Comprehensive Medical Plan offers two medical options. Both options are administered by UnitedHealthcare (UHC) and utilize the Choice Plus network of health care providers.

BCM PREMIUM PPO OPTION

- The BCM Premium PPO Option utilizes a network of physicians at special negotiated rates. Choice Plus network provider information is available online at www.myuhc.com/groups/bcm, or you can call 1-877-BAYLOR1 (1-877-229-5671).
- You can go to any physician or medical facility for services in a PPO regardless of whether they are in or out-of-network. Your annual deductible, copayment levels, and annual out-of-pocket maximum will be affected by whether or not you use a network physician or medical facility.
- There is a deductible if you use a network facility or hospital. The deductible does **not** apply to physician office visits; however, a copay is required.
- Emergency room (ER) treatment within the network is subject to a copay, and the remaining expenses are paid at 80% after your deductible is met until you reach your out-of-pocket maximum.
- Any covered services provided in an in-network Urgent Care or Convenience Care facility will be subject to a copay.
- Copays do not apply toward the deductible, including copays for prescription drugs and visits to physicians, Urgent Care facilities, or ERs.
- Coinsurance and deductible payments apply toward the out-of-pocket maximum. For example, if you are required to pay 20% of the network medical expense, that dollar amount will go toward satisfying your annual out-of-pocket maximum.
- Any service provided in a network physician's office including charges for office visits, treatment, and testing will be subject to one copay (copay based on Primary Care or Specialist services). This includes allergy testing and injections, lab work, or x-rays done in the physician's office.
- If you select a physician *outside* the Choice Plus network (out-of-network), your expenses are subject to a larger deductible, and reasonable and customary (R&C) limits are paid at a 60% coinsurance rate.
- When you reach your annual out-of-pocket maximum, R&C fees are paid at 100% for the remainder of the calendar year. Specific out-of-pocket limits are shown on the *2012 Medical Plan Options Comparison* located on the next page.

BCM VALUE EPO OPTION

- The Value EPO Option provides coverage for only those expenses provided exclusively by Choice Plus network providers. If you seek treatment from an out-of-network provider, **no benefits will be paid** (unless it is a life threatening emergency). Choice Plus network provider information is available online at www.myuhc.com/groups/bcm, or you can call 1-877-BAYLOR1 (1-877-229-5671).
- There is a deductible if you use a network facility or hospital. The deductible does **not** apply to physician office visits; however, a copay is required.
- Emergency room (ER) treatment within the network is subject to a copay, and the remaining expenses are paid at 80% after your deductible is met until you reach your out-of-pocket maximum.
- Any covered service provided in an in-network Urgent Care or Convenience Care facility will be subject to a copay.
- The Value EPO Option covers the same in-network services as the Premium PPO Option; however, the deductibles, copays, and/or coinsurance amounts may be different. Please refer to the *2012 Medical Plan Options Comparison* located on the next page.

MEDICAL PLANS	YOU PAY		BCM PAYS	TOTAL MONTHLY COST
	BI-WEEKLY	MONTHLY	MONTHLY	
BCM PREMIUM PPO				
Employee Only	\$ 67.55	\$ 146.36	\$ 383.63	\$ 529.99
Employee + Spouse*	\$ 169.36	\$ 366.95	\$ 717.94	\$ 1084.89
Employee + Child(ren)	\$ 161.11	\$ 349.07	\$ 609.96	\$ 959.03
Employee + Family*	\$ 251.45	\$ 544.81	\$ 1029.57	\$ 1574.38
BCM VALUE EPO				
Employee Only	\$ 21.69	\$ 46.99	\$ 448.33	\$ 495.32
Employee + Spouse*	\$ 73.98	\$ 160.28	\$ 853.64	\$ 1013.92
Employee + Child(ren)	\$ 65.40	\$ 141.70	\$ 754.58	\$ 896.28
Employee + Family*	\$ 128.83	\$ 279.14	\$ 1192.24	\$ 1471.38

*If you are providing coverage for your domestic partner who is not a tax dependent, the portion of the premium relating to your domestic partner will be deducted on an after-tax basis and the balance of the premium will be paid on a pre-tax basis. Contact HR-Benefits at 713-798-1500 or ask-insurance@bcm.edu if you have additional questions.

TERMS YOU NEED TO KNOW

Coinsurance – percent of expense you pay

Convenience Care Facility – health care clinics located in retail stores, supermarkets, and pharmacies that treat minor illnesses and provide preventive health care services (i.e., BCM Express Care Center, CVS Minute Clinic, and Walgreens Take Care Clinic, etc.)

Copay – fee you pay for specific services in plan

Deductible – amount you pay before the Plan begins to pay

Emergency Care – care provided due to acute life-threatening situations including excessive bleeding, chest pains, loss of consciousness

In-network – services you receive from physicians/hospitals within the network (fees have been discounted)

Newborn Care – Any claim for a newborn that experiences health issues (including jaundice) will not be processed until the baby is added as your dependent within 31 days of birth

Out-of-network – services you receive from a physician or hospital outside the network (you pay retail for these services) and charges are subject to R&C

Out-of-pocket – how much you pay before the Plan begins to pay 100% of claims for the remainder of the calendar year

PCP – a primary care physician (PCP) is a medical doctor who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions (All doctors consisting of Family Practice, General Practice, Internal Medicine, and Pediatrics.)

R&C – Reasonable & Customary limit for specific service or supply

Urgent Care Facility – a facility used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room

2012 MEDICAL PLAN OPTIONS COMPARISON CHART

SERVICES	BCM PREMIUM PPO		BCM VALUE EPO
	NETWORK	OUT-OF-NETWORK	NETWORK ONLY
ANNUAL MAXIMUM	No more than \$2,000,000 in any one calendar year per covered person		
ANNUAL DEDUCTIBLE	\$250 per person/\$500 per family	\$700 per person/\$1,400 per family	\$500 per person/\$1,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,000 per person/\$6,000 per family	\$8,000 per person/\$16,000 per family	\$4,000 per person/\$8,000 per family
ALLERGY EVALUATION & TESTING	\$25 copay (in doctor's office)	Plan pays 60% after deductible	\$35 copay (in doctor's office)
ALLERGY AND OTHER INJECTIONS	\$15 copay in doctor's office (primary care) \$25 copay in doctor's office (specialty)	Plan pays 60% after deductible	\$20 copay in doctor's office (primary care) \$35 copay in doctor's office (specialty)
AMBULANCE SERVICE	Plan pays 80%	Plan pays 80%	Plan pays 80%
ANCILLARY SERVICES SUCH AS: • RADIOLOGY • PATHOLOGY • ANESTHESIOLOGY • LABORATORY • X-RAY	\$15 copay in doctor's office (primary care) \$25 copay in doctor's office (specialty) <i>Plan pays 80% after deductible if service performed in network hospital setting or ancillary facility</i>	Plan pays 60% after deductible	\$20 copay in doctor's office (primary care) \$35 copay in doctor's office (specialty) <i>Plan pays 80% after deductible if service performed in network hospital setting or ancillary facility</i>
CHEMICAL DEPENDENCY/MENTAL HEALTH – INPATIENT*	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible
CHEMICAL DEPENDENCY/MENTAL HEALTH – OUTPATIENT	\$15 copay	Plan pays 60% after deductible	\$20 copay
CHIROPRACTIC MANIPULATION	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible
Limited to \$2,000 per calendar year			
CONVENIENCE CARE FACILITY	\$15 copay (no deductible/coinsurance)	Plan pays 60% after deductible	\$20 copay (no deductible/coinsurance)
DOCTOR'S OFFICE VISIT	\$15 copay (primary care) \$25 copay (specialty)	Plan pays 60% after deductible	\$20 copay (primary care) \$35 copay (specialty)
DURABLE MEDICAL EQUIPMENT*	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible
Pre-authorization required for any item more than \$1,000, calendar year maximum \$2500			
EMERGENCY ROOM CARE ACUTE LIFE-THREATENING SITUATIONS (EXCESSIVE BLEEDING/CHEST PAINS/LOSS OF CONSCIOUSNESS)	Plan pays 80% after you pay \$100 copay and deductible <i>(Emergency care copay waived if admitted)</i>	Plan pays 80% after you pay \$100 copay and deductible <i>(Emergency care copay waived if admitted)</i>	Plan pays 80% after you pay \$100 copay and deductible <i>(Emergency care copay waived if admitted)</i>
HOSPITAL STAY - INPATIENT*	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible
INFERTILITY TESTING & TREATMENT	\$25 copay in doctor's office (specialty) Plan pays 80% after deductible if not in doctor's office	Plan pays 60% after deductible	\$35 copay in doctor's office (specialty) Plan pays 80% after deductible if not in doctor's office
Lifetime maximum \$10,000 (Prescription drugs are handled under the Prescription Drug Program and accumulate toward the lifetime maximum)			
MATERNITY – INPATIENT*	Plan pays 80% after deductible	Plan pays 60% deductible	Plan pays 80% after deductible
MATERNITY – OUTPATIENT	\$25 copay (specialty) – applies to initial prenatal office visit only	Plan pays 60% after deductible	\$35 copay (specialty) – applies to initial prenatal office visit only
NEWBORN CARE – INPATIENT*	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible
Charges will not be covered unless newborn is enrolled within 31 days of birth. Contact Benefits at 713-798-1500.			
OUTPATIENT SURGERY*	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible
THERAPY: • PHYSICAL • CARDIAC • SPEECH • PULMONARY • OCCUPATIONAL	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible
60 visits per condition annually (limits apply) – See SPD for details			
PRESCRIPTION DRUGS	<ul style="list-style-type: none"> ▪ Short-term – 30-day supply (Retail) <ul style="list-style-type: none"> – \$ 10 copay for generic or contracted rate if less – \$ 40 copay for preferred formulary brand-name or contracted rate if less – \$ 60 copay for non-preferred formulary brand-name ▪ Mail-order – 90-day supply <ul style="list-style-type: none"> – \$ 20 copay for generic – \$ 80 copay for preferred brand-name – \$120 copay for non-preferred brand-name 	Not covered unless CVS/Caremark network pharmacy is used	<ul style="list-style-type: none"> ▪ Short-term – 30-day supply (Retail) <ul style="list-style-type: none"> – \$ 10 copay for generic or contracted rate if less – \$ 40 copay for preferred formulary brand-name or contracted rate if less – \$ 60 copay for non-preferred formulary brand-name ▪ Mail-order – 90-day supply <ul style="list-style-type: none"> – \$ 20 copay for generic – \$ 80 copay for preferred brand-name – \$120 copay for non-preferred brand-name
Brand Name drugs covered only when prescribed and specified in writing by a physician			
URGENT CARE FACILITY	\$50 copay **	Plan pays 60% after deductible**	\$50 copay**
WELLNESS BENEFIT – INCLUDING BUT NOT LIMITED TO: ANNUAL PHYSICAL, WELL-CHILD EXAM, WELL-WOMAN EXAM, MAMMOGRAMS, PROSTATE SCREENING	Plan pays 100%	Plan pays 100%	Plan pays 100%

*The Premium PPO requires pre-authorization for all out-of-network inpatient hospitalizations, inpatient chemical dependency/mental health stays, outpatient surgical procedures, home health care services, and skilled nursing services. All durable medical equipment over \$1000 regardless of network status must be pre-authorized. Failure to pre-authorize as stated will result in a \$500 penalty. Call United Healthcare at 1-877-BAYLOR1 (1-877-229-5671) at least 48 hours prior to the request.

**May be subject to deductible and coinsurance for ancillary services.

2012 HEALTH CARE CHOICES & COSTS

DENTAL PPO PLAN

BCM's Comprehensive Medical Plan offers one dental plan administered by United Healthcare (UHC). You can choose to seek dental treatment in the UHC dental network or outside the network. A higher level of dental benefit coverage is provided when you use UHC dental network providers. Your annual deductible and copayments are affected by whether or not you use a network or out-of-network provider. Network provider information is available at www.myuhc.com/groups/bcm.

SERVICE CATEGORY	NETWORK	OUT-OF-NETWORK	DESCRIPTION OF SERVICES	
Annual Deductible	\$50/participant	\$100/participant		
Basic & Major Services	\$150/family	\$300/family		
Annual Maximum Benefit for Basic & Major Services	\$3,000/participant	\$2,000/participant		
PREVENTIVE SERVICES				
You Pay	0%	20%	<ul style="list-style-type: none"> ▪ Two oral exams and cleanings per year ▪ Bitewing x-rays – limited to two series per calendar year ▪ Two periodontal prophylaxis per year ▪ Two fluoride treatments per year ▪ One panoramic mouth x-ray every 3 years ▪ Sealants every 3 years for children under age 16 	
Plan Pays	100%	80%		
BASIC SERVICES				
You Pay	10%	30%	<ul style="list-style-type: none"> ▪ Emergency palliative treatment ▪ Fillings ▪ Fixed space maintainers 	
Plan Pays	90%	70%		
MAJOR SERVICES				
You Pay	20%	50%	<ul style="list-style-type: none"> ▪ Inlays & Onlays ▪ Crowns ▪ Bridgework ▪ Dentures 	
Plan Pays	80%	50%		
ORTHODONTIA (CHILDREN THROUGH AGE 18)				
You Pay	40%	50%	<ul style="list-style-type: none"> ▪ Appliances and services to correct the positioning of teeth ▪ Benefit available for children through age 18 only 	
Plan Pays	60%	50%		
Lifetime Maximum	\$2,500/participant	\$1,500/participant		

*Oral Surgery – includes extractions and is subject to \$5,000 lifetime maximum

DENTAL PPO COSTS

COVERAGE LEVEL	YOU PAY		BCM PAYS	TOTAL MONTHLY COST
	BI-WEEKLY	MONTHLY	MONTHLY	
Individual Only	\$ 3.32	\$ 7.20	\$ 30.31	\$ 37.51
Individual + Spouse	\$ 14.93	\$ 32.34	\$ 57.65	\$ 89.99
Individual + Child(ren)	\$ 10.66	\$ 23.10	\$ 51.88	\$ 74.98
Individual + Family	\$ 27.72	\$ 60.06	\$ 74.93	\$ 134.99

VISION CARE PLAN

The Voluntary Vision Care Program is administered by EyeMed. Vision care services are provided at BCM's Alkek Eye Center, Lenscrafters, Pearle Vision, Sears Optical, and Target Optical. In addition, EyeMed provides a network of thousands of optometrists, opticians, and ophthalmologists. You can seek vision care services in the network or outside the network. Provider information is available to you online at www.eyemedvisioncare.com (Network = Access).

SERVICE CATEGORY	YOUR COST	OUT-OF-NETWORK REIMBURSEMENT
Exam with dilation as necessary	\$10 Copay	Up to \$40
Contact Lens (fit & follow-up)	Paid in full; includes fit and two follow-up visits 10% off retail price, then apply \$55 allowance	Up to \$40
<ul style="list-style-type: none"> ▪ Standard ▪ Premium 		
Frames	\$110 allowance; 20% off balance over \$110	Up to \$55
<ul style="list-style-type: none"> ▪ Standard Plastic Single Vision ▪ Bifocal ▪ Trifocal ▪ Standard Progressive ▪ Premium Progressive 	\$10 Copay \$10 Copay \$10 Copay \$10 Copay \$10 copay; 80% of charge less \$120 allowance	Up to \$25 Up to \$40 Up to \$65 Up to \$80 Up to \$80
Contact lenses (materials)	\$110 allowance; 15% off balance over \$110	Up to \$80
<ul style="list-style-type: none"> ▪ Conventional ▪ Disposables ▪ Medically necessary 		
LASIK and PRK Vision Correction	15% off retail price or 5% off promotional pricing	N/A

VISION CARE COSTS

COVERAGE LEVEL	YOU PAY		BCM PAYS	TOTAL MONTHLY COST
	BI-WEEKLY	MONTHLY	MONTHLY	
Individual Only	\$ 3.81	\$ 8.25	N/A	\$ 8.25
Individual + 1 Dependent	\$ 7.23	\$ 15.67	N/A	\$ 15.67
Individual + Family	\$ 10.66	\$ 23.09	N/A	\$ 23.09

2012 FSA, OPTIONAL LIFE INSURANCE AND AD&D CHOICES & COSTS

FLEXIBLE SPENDING ACCOUNTS (FSAs)

United Healthcare is the administrator for FSAs. FSAs are subject to Internal Revenue Service rules and regulations. You must plan carefully when using a FSA because if you don't use the money in your FSA, you lose it. **Expenses must be incurred in 2012 and you have until March 31, 2013 to file for reimbursement.** When submitting a FSA claim for reimbursement, keep proof of claim submission including fax confirmation sheet or proof of mailing from the U.S. Postal Service.

Health Care FSA

- Set money aside before federal income and FICA taxes are withheld for reimbursement of out-of-pocket health care expenses not covered by a medical, dental, and/or vision plan
- Health Care FSA maximum of \$5,000 on a pre-tax basis
- Some eligible FSA expenses include your deductible, adult or children's orthodontics, lasik surgery, copays for office visits or prescription drugs, and certain over-the-counter drugs as defined in the Patient Protection and Affordable Care Act
- Automatic reimbursement for Health Care FSA reimbursement is no longer available on ESS. You must enroll for automatic reimbursement on www.myuhc.com.

Dependent Care FSA

- Set money aside before federal income and FICA taxes are withheld for reimbursement of child care and elder care expenses
- Dependent Care FSA maximum of \$5,000 per family on a pre-tax basis
- To be eligible for Dependent Care FSA reimbursement, you must be dependent upon a care provider in order to go to work

Healthcare Spending Account Card (also used for Dependent Care expenses, if applicable)

- Provided to all employees who participate in an FSA
- Instant payment for qualified medical, prescription, dental, vision care, and dependent care expenses directly from your FSA account

SUPPLEMENTAL LIFE INSURANCE

- Life insurance coverage in addition to the Basic Life insurance benefit provided by BCM at no cost to you (two times your base annual salary)
 - Choices are an additional one, two, three, or four times your base annual salary including applicable fee income
 - Cost is based on age
 - Rates are based on monthly cost per \$1,000 of coverage with a \$500,000 maximum
 - These premiums are not subject to pre-tax treatment and may increase during the calendar year due to change in age or salary

Example: If you earn \$40,000 and are 37 years of age and you elect Supplemental Life coverage at two times your base annual salary, your amount of supplemental coverage is \$80,000 and your age factor is \$.068 per \$1,000 of coverage. Divide \$80,000 by 1,000 and multiply the result by \$.068 to calculate your monthly premium. ($\$40,000 \times 2 = \$80,000 \div 1,000 = 80 \times \$.068 = \$5.44/\text{mo.}$)

DEPENDENT LIFE INSURANCE

- Life insurance coverage for your dependents [spouse/domestic partner and/or child(ren)]
 - Spouse/Domestic Partner - \$25,000
 - Child - \$5,000 for each eligible dependent child (up to age 26)
 - Cost is based on your age
 - Rates are a flat monthly rate
 - These premiums are not subject to pre-tax treatment

YOUR AGE	SUPPLEMENTAL LIFE COST PER \$1,000 COVERAGE	DEPENDENT LIFE FLAT MONTHLY RATE	YOUR AGE	SUPPLEMENTAL LIFE COST PER \$1,000 COVERAGE	DEPENDENT LIFE FLAT MONTHLY RATE
Less than 30	\$.047	\$ 2.55	55 – 59	\$.473	\$ 13.27
30 – 34	.054	2.55	60 – 64	.668	20.07
35 – 39	.068	3.24	65 – 69	1.269	30.55
40 – 44	.101	4.43	70 – 74	2.012	47.42
45 – 49	.176	5.79	75 – 79	2.012	64.13
50 – 54	.290	8.51	80 +	2.012	64.13

SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

- Supplemental AD&D insurance coverage is in addition to the Basic AD&D insurance benefit provided by BCM at no cost to you (one times your base annual salary)
 - Choices are available in increments of \$100,000 up to a maximum election of \$1,000,000
 - Coverage can be elected for yourself only or you and your eligible dependents
 - Cost is based on the principal sum of insurance in force
 - These premiums are not subject to pre-tax treatment

COVERAGE OPTION	EMPLOYEE ONLY FLAT MONTHLY RATE	EMPLOYEE + FAMILY FLAT MONTHLY RATE
\$ 100,000	\$ 2.00	\$ 3.50
200,000	4.00	7.00
300,000	6.00	10.50
400,000	8.00	14.00
500,000	10.00	17.50
600,000	12.00	21.00
700,000	14.00	24.50
800,000	16.00	28.00
900,000	18.00	31.50
1,000,000	20.00	35.00
FAMILY COVERAGE: Spouse/Domestic Partner Child or Children	WITH CHILDREN 50% of Employee Coverage \$25,000 Each Child	WITHOUT CHILDREN 60% of Employee Coverage

2012 VOLUNTARY PROGRAMS CHOICES & COSTS

VOLUNTARY SHORT TERM DISABILITY (STD)

- An insurance product through Unum Insurance Company
- Convenient payroll deductions
- Coverage is 60% of your weekly salary up to a maximum of \$3,000 per month
- Cost is 100% employee-paid and premium amount is based on your age
 - \$1.13 per \$10 of covered weekly salary for ages 17- 49
 - \$1.51 per \$10 of covered weekly salary for ages 50 - 79
- Premiums are not subject to pre-tax treatment and STD benefits received are tax free
- **Enrollment/cancellation required by telephone at 877-317-8451**

VOLUNTARY GROUP LEGAL SERVICES

- Legal services at a low monthly fee for you and your eligible dependents through Hyatt Legal Plans, a MetLife Company
- Provides access to experienced attorneys to assist you by telephone or in person
- Examples of some covered services are wills, codicils, living wills, powers of attorney, living trusts, consumer protection, identity theft defense, traffic ticket dismissal, and more
- Cost is \$20 per month (\$9.23 per bi-weekly payroll deduction)
- More detailed information is available at www.legalplans.com (password: 100610) or by telephone at 800-821-6400
- **Enrollment/cancellation required by telephone at 800-821-6400**

CNA LONG TERM CARE

- An insurance product – contact CNA at the phone number below for an enrollment packet that includes rates and an application
- Provides a daily benefit for persons with prolonged physical illness, disability, or cognitive disorders to help them maintain their level of functioning
- Includes daily activities (bathing, dressing, and eating; home health care; adult health care; care in a nursing home)
- Coverage choices are a maximum daily benefit for a long term facility of \$100/day, \$200/day, or \$300/day (*Evidence of Insurability may be required*)
- More detailed information and costs are available at www.ltcbenefits.com (password: Baylor) or by telephone at 877-777-9072
- **Enrollment/cancellation required by telephone at 877-777-9072**