Clear form

2021 PEBB Continuation Coverage (Unpaid Leave) Election/Change

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

We must receive this form **no later than 60 days** from the date your PEBB health plan coverage ends or from the postmark date on the *PEBB Continuation Coverage Election Notice* sent to you, whichever is later.

Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends. We will not enroll you in coverage until we receive your first payment. If HCA does not receive your first payment during this 45-day timeframe, you will not be enrolled, and you will lose your rights for PEBB Continuation Coverage (Unpaid Leave). Premiums and applicable premium surcharges are due from the date your other coverage ended. This form replaces all *PEBB Continuation Coverage (Unpaid Leave) Election/Change* forms submitted in the past.

All forms and documents are available on HCA's website at **hca.wa.gov/pebb-continuation** under *Forms & publications* or by calling 1-800-200-1004 (TRS: 711).

Type or print clearly in dark ink and use all capital lettering in the spaces provided. Inaccurate, incomplete, or illegible information may delay coverage. Example: J O H N

Remember to read and sign Section 9. To enroll or remove children, complete Section 10 at the end of this form.

1 Qualifying event

Check only one.

- ☐ Applying for disability retirement
- ☐ Layoff
- ☐ Reversion employee (for reasons other than a layoff)
- ☐ Approved Leave Without Pay (LWOP)
- ☐ Workers' compensation
- ☐ Approved educational leave
- ☐ Faculty between periods of eligibility
- ☐ Seasonal employee off-season
- ☐ Employee appealing a dismissal action
- ☐ USERRA (military) leave Date called to duty in the uniformed services

2 Subscriber

Date employer coverage ended

Social Security number

Date of birth

Sex assigned at birth[1]
☐ Male ☐ Female

Last name

Gender identity[2]
☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

1 *This field is required for health care services.*
2 *Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit* **hca.wa.gov/gender-x**.

2021 PEBB Continuation Coverage (Unpaid Leave) Election/Change

Subscriber's last name

Social Security number

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

You must report your new address to the PEBB Program **no later than 60 days** after you move. You can report it by using this form, sending a written request to the address listed on page 11 of this form, or calling 1-800-200-1004 (TRS: 711).

Are you or any eligible dependents enrolled in PEBB insurance coverage under another account?

☐ Yes ☐ No

Continue coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Life and accidental death and dismemberment (AD&D) insurance

☐ Long-term disability insurance (only if on educational or USERRA military leave)

Add coverage (Select all that apply.)

☐ Medical ☐ Dental

Terminate coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Long-term disability insurance (only if on educational or USERRA military leave)

Termination date

If terminating coverage, include reason

If you are enrolled in a Medical Flexible Spending Arrangement (FSA) and would like to continue it, call Navia Benefit Solutions at 1-800-669-3539 **no later than 60 days** after the mailing date on the *PEBB Continuation Coverage Election Notice.*

To terminate life or AD&D insurance, call MetLife at 1-866-548-7139.

2021 PEBB Continuation Coverage (Unpaid Leave) Election/Change

Subscriber's last name

Social Security number

Tobacco use premium surcharge

Response required if you are enrolling in medical coverage. The PEBB Program requires a $25-per-account tobacco use premium surcharge in addition to your monthly medical premium if you or a dependent (age 13 or older) enrolled on your PEBB medical uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use.

If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in the PEBB Program Administrative Policy 91-1 at **hca.wa.gov/pebb-rules**.

If you check **Yes** or do not check any boxes below, you will be charged the $25 premium surcharge. See the *2021 PEBB Premium Surcharge Attestation Help Sheet* on HCA's website at **hca.wa.gov/pebb-continuation** for instructions on how to respond.

Does the tobacco use premium surcharge apply to you? Check one:

☐ **Yes**, I am subject to the $25 premium surcharge. I have used tobacco products in the past two months. If this is a change to a previous attestation, submit the P*EBB Premium Surcharge Attestation Change Form*.

☐ **No**, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have enrolled in or accessed one of the tobacco cessation resources noted in the *PEBB Premium Surcharge Attestation Help Sheet*.

Subscriber's last name

Social Security number

3 Spouse or state-registered domestic partner (SRDP)

List an eligible spouse or state-registered domestic partner (SRDP), as defined by Washington Administrative Code 182-12-109, you wish to enroll or remove from coverage. To enroll or remove children, please complete Section 10 at the end of this form. Your spouse or SRDP cannot be enrolled in two PEBB medical or dental accounts at the same time.

Relationship to subscriber

☐ Spouse: date of marriage

☐ SRDP: date registered

If enrolling a SRDP, attach a *2021 PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(B). You must also provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. A list of documents we will accept to verify eligibility is available on HCA's website at **hca.wa.gov/pebb-continuation**.

Social Security number

Date of birth

Sex assigned at birth[1]

☐ Male ☐ Female

Last name

Gender identity[2]

☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

Continue coverage (Select all that apply.)

☐ Medical ☐ Dental

Add coverage (Select all that apply.)

☐ Medical ☐ Dental

If removing a spouse due to divorce, attach a copy of the divorce decree. If removing a SRDP due to dissolution, attach a copy of the dissolution of state-registered domestic partnership.

Terminate coverage (Select all that apply.)

☐ Medical ☐ Dental Termination date

If terminating coverage, include reason

To terminate life or AD&D insurance, call MetLife at 1-866-548-7139.

1 *This field is required for health care services.*

2 *Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit* **hca.wa.gov/gender-x**.

2021 PEBB Continuation Coverage (Unpaid Leave) Election/Change

Subscriber's last name

Social Security number

Tobacco use premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. If you check **Yes** or do not check any boxes below, you will be charged the $25-per-account tobacco use premium surcharge in addition to your monthly medical premium.

Does the tobacco use premium surcharge apply to you? Check one:

- **Yes**, I am subject to the $25 premium surcharge. This dependent has used tobacco products in the past two months. If this is a change to a previous attestation, use the *PEBB Premium Surcharge Attestation Change Form*.
- **No**, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *PEBB Premium Surcharge Attestation Help Sheet*.

Spouse or state-registered domestic partner (SRDP) coverage premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you are enrolling your spouse or SRDP in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to Uniform Medical Plan (UMP) Classic. See the *2021 PEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond. If you check **Yes** below or leave this section blank, you will be charged the $50 premium surcharge.

Does the spouse or SRDP coverage premium surcharge apply to you? Check one:

- **Yes**, I am subject to the $50 premium surcharge. I used the *PEBB Premium Surcharge Attestation Help Sheet* and completed the *2021 PEBB Spousal Plan Calculator*.
- **No**, I am not subject to the $50 premium surcharge. I used the *PEBB Premium Surcharge Attestation Help Sheet* and, if needed, completed the *PEBB Spousal Plan Calculator*. Which questions, if any, on the *PEBB Premium Surcharge Attestation Help Sheet* did you check No? **Check all that apply**. Question 1 is not applicable.
  - Question 2
  - Question 3
  - Question 4
  - Question 5
  - Question 6
- PEBB Program to help determine if premium surcharge applies. I used the *PEBB Premium Surcharge Attestation Help Sheet* and am submitting a printed *PEBB Spousal Plan Calculator*. The PEBB Program will use these to help determine whether my spouse's or SRDP's employer-based group medical is comparable to UMP Classic and whether I am subject to this premium surcharge.

The *PEBB Premium Surcharge Attestation Help Sheet* and *PEBB Spousal Plan Calculator* are available on HCA's website at **hca.wa.gov/pebb-continuation** under *Forms & publications*.

2021 PEBB Continuation Coverage (Unpaid Leave) Election/Change

Subscriber's last name

Social Security number

4 Changes to an existing account

Are you making changes to an existing account?

☐ Yes If yes, check all changes that apply in the section below.

Date of event/change:

☐ No If no, continue to Section 5.

Changes you can make anytime

☐ Name change

☐ Address change

☐ Terminate medical coverage for you or your enrolled dependents

☐ Terminate dental coverage for your or your enrolled dependents

☐ Remove dependents from coverage. If removal is due to loss of eligibility (divorce, annulment, dissolution, or dependent ceasing to be eligible as a child). The PEBB Program must receive this form and proof of the event **no later than 60 days** after the last day of the month the dependent loses eligibility. Coverage will be terminated the last day of the month of loss of eligibility. If applicable, provide your former dependent's new address:

Street address

Address line 2

City State

ZIP/Postal code

Additional changes you can make during annual open enrollment

All changes become effective January 1 of the following year.
Check the box next to the changes requested.

☐ Add dependents

☐ Remove dependents

☐ Add or change medical plan

☐ Add or change dental plan

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Subscriber's last name

Social Security number

Changes you can make if an event creates a special open enrollment (SOE)

The PEBB Program only allows changes outside of annual open enrollment when an event creates an SOE. The PEBB Program must receive this form and proof of the event **no later than 60 days** after the event occurs. In most cases, the enrollment or change will be effective the first day of the month after the event date or the date we receive the form, whichever is later.

To enroll a newborn or a child whom you, the subscriber, have adopted (or have assumed legal responsibility for support ahead of adoption), you should notify the PEBB Program by submitting the required forms as soon as possible. Doing so ensures timely payment of claims. If adding the child increases the premium, the required forms must be received **no later than 60 days** after the date of the birth, adoption, or the date the legal responsibility for support is assumed ahead of adoption.

Check the box next to the corresponding events below.

The following events allow a subscriber to enroll dependents or change medical or dental plans:

- Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete a *2021 PEBB Extended Dependent Certification* and *2021 PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).
- Subscriber or dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- Subscriber or dependent enrolls in or loses eligibility for coverage under Medicaid or a state Children's Health Insurance Program (CHIP).
- Subscriber or dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal responsibility for support ahead of adoption. You must also submit a *PEBB Declaration of Tax Status* if adding a state-registered domestic partner or their child to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

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Subscriber's last name

Social Security number

The following events allow a subscriber to enroll dependents:

- Subscriber or dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- Subscriber's dependent has a change in residence from another country to within the United States or from the United States to another country, and that change resulted in the dependent losing their health insurance.

The following events allow medical or dental plan changes:

- Subscriber or dependent has a change in residence that affects health plan availability.
- Subscriber or dependent enrolls in or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Advantage Prescription Drug plan or Medicare Part D plan.
- Subscriber or dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.
- Subscriber or dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent (requires approval by the PEBB Program).

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Subscriber's last name

Social Security number

5 Medical plan selection

Call the medical plans you are interested in to make sure your provider is in the network. Contact the plans for details about benefits. Their contact information is on page 13.

If you move out of the medical plan's service area you may need to change plans. You must report your new address to the PEBB Program **no later than 60 days** after you move by using this form, sending a written request to the address listed on page 11, or calling 1-800-200-1004 (TRS: 711).

Choose one medical plan.

Kaiser Foundation Health Plan of the Northwest[1]

- Kaiser Permanente NW[2] Classic
- Kaiser Permanente NW[2] Consumer-Directed Health Plan

Kaiser Foundation Health Plan of Washington[1]

- Kaiser Permanente WA Classic
- Kaiser Permanente WA Consumer-Directed Health Plan
- Kaiser Permanente WA SoundChoice[3]
- Kaiser Permanente WA Value

Uniform Medical Plan (UMP), administered by Regence BlueShield

- UMP Classic
- UMP Select
- UMP Consumer-Directed Health Plan
- UMP Plus—Puget Sound High Value Network[1]
- UMP Plus—UW Medicine Accountable Care Network[1]

1. These plans have a specific service area. If you move out of the service area, you must change your plan; otherwise you will have limited access to network providers and covered services. You must notify the PEBB Program **no later than 60 days** after you move.
2. Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.
3. Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before you visit.

6 Dental plan selection

Choose one dental plan in this section.

Preferred Provider Organization (PPO)

- **Uniform Dental Plan** (Group #03000), administered by Delta Dental of Washington. You can choose any dental provider and change providers at any time.

Managed-Care Plans (limited network)

- **DeltaCare** (Group #03100), administered by Delta Dental of Washington. You must select a primary care dentist in the DeltaCare network. Before you enroll, call DeltaCare at 1-800-650-1583 to verify your provider accepts the specific plan network and plan group.
- **Willamette Dental of Washington, Inc.** (Group WA 82), administered by Willamette Dental Group You will select and receive care from a primary care dental provider in the Willamette Dental Group Plan. Before you enroll, call 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

Subscriber's last name

Social Security number

7 Life and accidental death and dismemberment (AD&D) insurance

☐ **Yes**, I wish to continue the life and AD&D insurance I had as an employee. I understand I will need to pay MetLife for basic life insurance and basic AD&D Insurance in addition to any supplemental life and AD&D insurance I have while on PEBB Continuation Coverage (Unpaid Leave). If you wish to decrease your supplemental life and/or AD&D insurance amounts while on PEBB Continuation Coverage (Unpaid Leave), please call MetLife at 1-866-548-7139.

☐ **No**, I do not wish to continue the life and AD&D insurance I had as an employee. I understand I must reapply for supplemental life insurance and AD&D insurance when I regain eligibility and I must submit evidence of insurability to MetLife for supplemental life insurance. I understand that MetLife must receive my *MetLife Enrollment/Change form* through MetLife's online portal at **mybenefits.metlife.com/wapebb** **no later than 31 days** after the date I regain eligibility.

8 Long-term disability (LTD) insurance

This section applies only to employees on approved educational leave, or who are called to active duty in the uniformed services as defined under Uniformed Services Employment and Reemployment Rights Act (USERRA).

Current enrollment with employing agency

☐ Basic LTD coverage ($2.10/month)

☐ Supplemental LTD coverage (select a waiting period)

- ☐ 90-day
- ☐ 180-day
- ☐ 300-day
- ☐ 120-day
- ☐ 240-day
- ☐ 360-day

Desired enrollment while self-paying

☐ I wish to keep the same basic LTD insurance I had as an employee, and increase the supplemental LTD insurance waiting period. I understand I must reapply for the lower waiting period under supplemental LTD insurance and submit evidence of insurability to The Standard for approval when I regain eligibility for the employer contribution. I understand my employing agency must receive the required enrollment forms no later than 31 days after the date I regain eligibility.

Initial

☐ I do not wish to keep the LTD insurance I had as an employee. I understand I must reapply for the supplemental LTD insurance and submit evidence of insurability to The Standard for approval when I regain eligibility for the employer contribution. I understand my employing agency must receive the required enrollment forms no later than 31 days after the date I regain eligibility.

initial

☐ I wish to keep the same coverage I had as an employee.

Initial

2021 PEBB Continuation Coverage (Unpaid Leave) Election/Change

Subscriber's last name

Social Security number

9 Signature

I have received and read the *PEBB Continuation Coverage Election Notice,* including any appendices. By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s). My dependents and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of PEBB Program benefits.

If I send payment, this does not mean that I will be automatically enrolled in PEBB insurance coverage.

The PEBB Program will verify eligibility for my dependents and me. If we do not qualify, I will receive a refund.

I understand I am responsible for paying any applicable tobacco use premium surcharge and spouse or state-registered domestic partner coverage premium surcharge in addition to my monthly medical premium.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the PEBB Program will direct a portion of my monthly premium to an HSA on my behalf based on the information I have provided, and that there are limits to these contributions and my HSA contributions (if any) under federal tax law.

I understand that my enrollment and my dependents' enrollment are subject to me abiding by all applicable deadlines and PEBB Program rules and policies. Failure to comply with applicable deadlines and PEBB Program rules and policies may result in my benefits selection being rejected. This form replaces all *PEBB Continuation Coverage (Unpaid Leave) Election/Change* forms previously submitted to the PEBB Program.

Subscriber's signature

Date

Please sign, date, and keep a copy for your records. Submit form and documentation using one of the methods below:

Mail to:	**Fax to:**	**Electronically submit:**
Health Care Authority PO Box 42684 Olympia, WA 98504-2684	360-725-0771	Send a secure online message to PEBB Customer Service by registering for an account at **hca.wa.gov/fuze-questions**. Sign and date any forms you attach to a secure message.

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please call the PEBB Program at 1-800-200-1004 (TRS: 711).

HCA's Privacy Notice: HCA will keep your information private as allowed by law. To see our Privacy Notice, go to **hca.wa.gov/pebb-continuation**.

2021 PEBB Continuation Coverage (Unpaid Leave) Election/Change

Subscriber's last name

Social Security number

10 Dependents

List eligible dependents you wish to enroll or remove from coverage. Enrolled children must be eligible under PEBB Program rules. This includes children through the month of their 26th birthday regardless of marital status, student status, or eligibility for coverage under another plan and dependent children age 26 or older with a disability.

Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.

If enrolling a state-registered domestic partner's child, extended dependent, or other nonqualified tax dependent, also attach a *2021 PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

If enrolling an extended dependent, attach a *2021 PEBB Extended Dependent Certification*, a valid court order showing legal custody or guardianship, and a *PEBB Declaration of Tax Status*.

If enrolling a child with a disability age 26 or older, also submit a *2021 PEBB Certification of a Child with a Disability* and return as instructed.

Relationship to subscriber

- Child
- Stepchild (not legally adopted)
- Extended dependent (attach copy of court order)
- Child with a disability age 26 or older

If adding two or more dependents, copy pages 12 and 13 and attach to this form.

Social Security number

Date of birth

Sex assigned at birth[1]
Male Female

Last name

Gender identity[2]
Male Female X

First name

Middle initial

Suffix

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

Select all that apply.

Continue coverage	Add coverage	Terminate coverage
Medical Dental	Medical Dental	Medical Dental

If terminating coverage, include reason

Termination date

To terminate life and AD&D insurance, call MetLife at 1-866-548-7139.

1 *This field is required for health care services.*

2 *Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit* **hca.wa.gov/gender-x**.

2021 PEBB Continuation Coverage (Unpaid Leave) Election/Change

Subscriber's last name

Social Security number

Tobacco use premium surcharge

Response required for dependents age 13 or older enrolling in medical coverage. If you check **Yes** or do not check any boxes below, you will be charged the $25-per-account tobacco use premium surcharge in addition to your monthly medical premium. See the *2021 PEBB Premium Surcharge Attestation Help Sheet* on HCA's website at **hca.wa.gov/pebb-continuation** for instructions on how to respond.

Does the tobacco use premium surcharge apply to you? Check one:

☐ **Yes,** I am subject to the $25 premium surcharge. This dependent has used tobacco products in the past two months. If this is a change to a previous attestation, submit the *PEBB Premium Surcharge Attestation Change Form*.

☐ **No,** I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months, or has enrolled in or accessed one of the tobacco cessation resources noted in the *PEBB Premium Surcharge Attestation Help Sheet.*

2021 PEBB Program contractors

Do not send forms to the addresses below. This information is only for reference only.

Medical contractors

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St.
Suite 100
Portland, OR 97232-2099
1-800-813-2000 (TTY: 711)

Kaiser Foundation Health Plan of Washington
601 Union St.
Suite 3100
Seattle, WA 98101-1374
1-866-648-1928 (TTY: 1-800-833-6388)

Uniform Medical Plan, administered by Regence BlueShield
1800 Ninth Avenue
Suite 235
Seattle, WA 98101
1-888-849-3681 (TRS: 711)

Uniform Medical Plan, administered by Washington State Rx Services (for prescription drug questions)
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

Dental contractors

DeltaCare, administered by Delta Dental of Washington
400 Fairview Ave. N.
Suite 800
Seattle, WA 98109-5371
1-800-650-1583

Uniform Dental Plan, administered by Delta Dental of Washington
400 Fairview Ave. N.
Suite 800
Seattle, WA 98109-5371
1-800-537-3406

Willamette Dental of Washington, Inc.
6950 NE Campus Way,
Hillsboro, OR 97124-5611
1-855-4DENTAL (1-855-433-6825)

Life insurance contractor

Metropolitan Life insurance company (MetLife)
MetLife Recordkeeping Center
PO Box 14406
Lexington, KY 40512
1-866-548-7139

Long-term disability insurance contractor

The Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204
1-800-368-2860