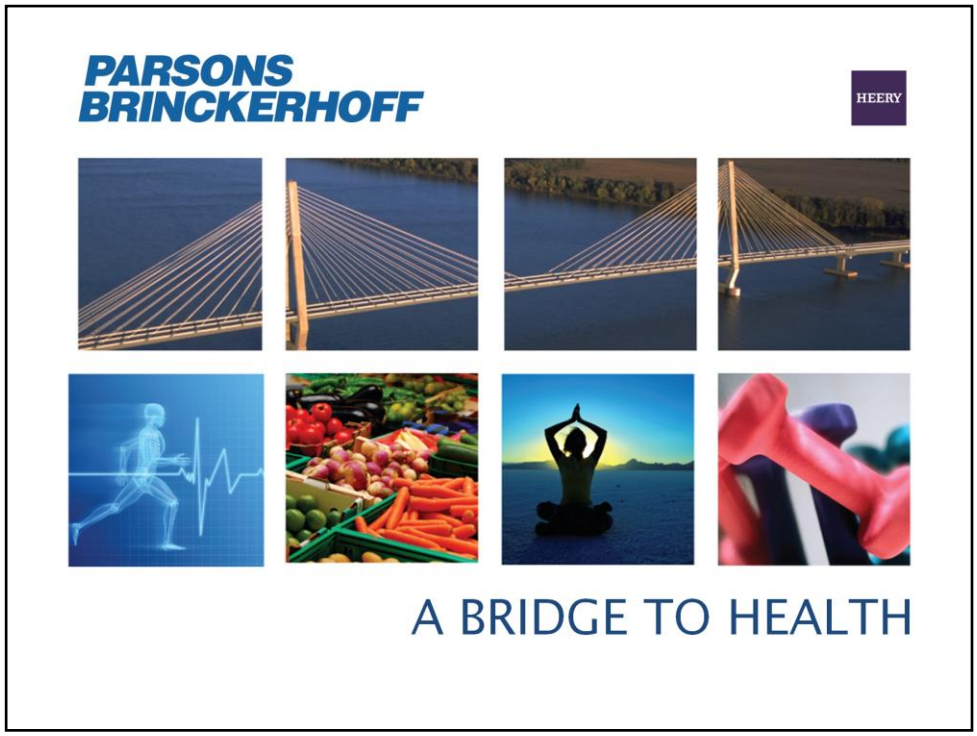
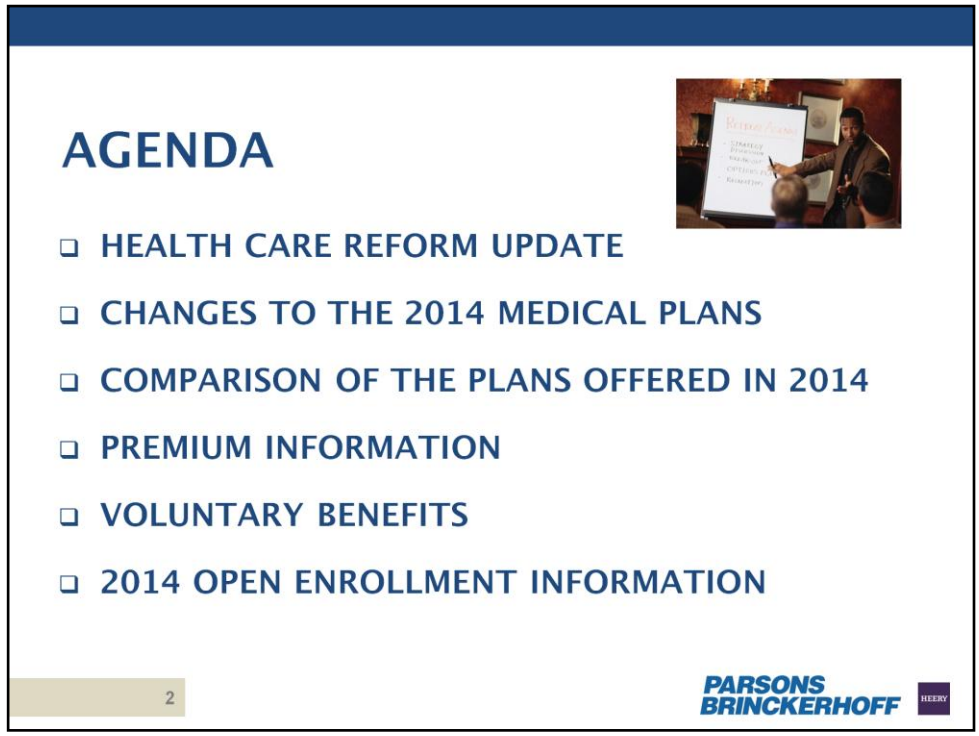


Welcome to the 2014 Open Enrollment Benefits Presentation for Parsons Brinckerhoff and Heery employees.



This presentation has valuable information on the 2014 benefit changes and the upcoming Open Enrollment period.

Topics covered during this presentation include:

A Health Care Reform Update,

Changes to the 2014 Medical Plans,

Comparison of the Plans Offered in 2014,

Premium Information,

Voluntary Benefits, and

2014 Open Enrollment Information.

The Individual Mandate requires everyone to obtain health insurance that meets the government's minimum coverage requirements or pay a tax penalty. If you need additional information on the Individual Mandate or other Patient Protection and Affordable Care Act (PPACA) regulations, visit www.healthcare.gov.

Health Care Exchanges began accepting applications October 1, 2013 with coverage effective January 1, 2014. The Exchange Notice was distributed to all employees on October 1, 2013. The Exchange Notice is posted on 360, Human Resources, Benefits.

The annual $2 million claim maximum in our medical plans will be eliminated.

2014 HEALTH CARE REFORM CHANGES

- **100% COVERAGE**
  - Preventive Care Services
  - Selected Over-the-Counter Medications
  - BRCA Testing
  - Comprehensive Lactation Support

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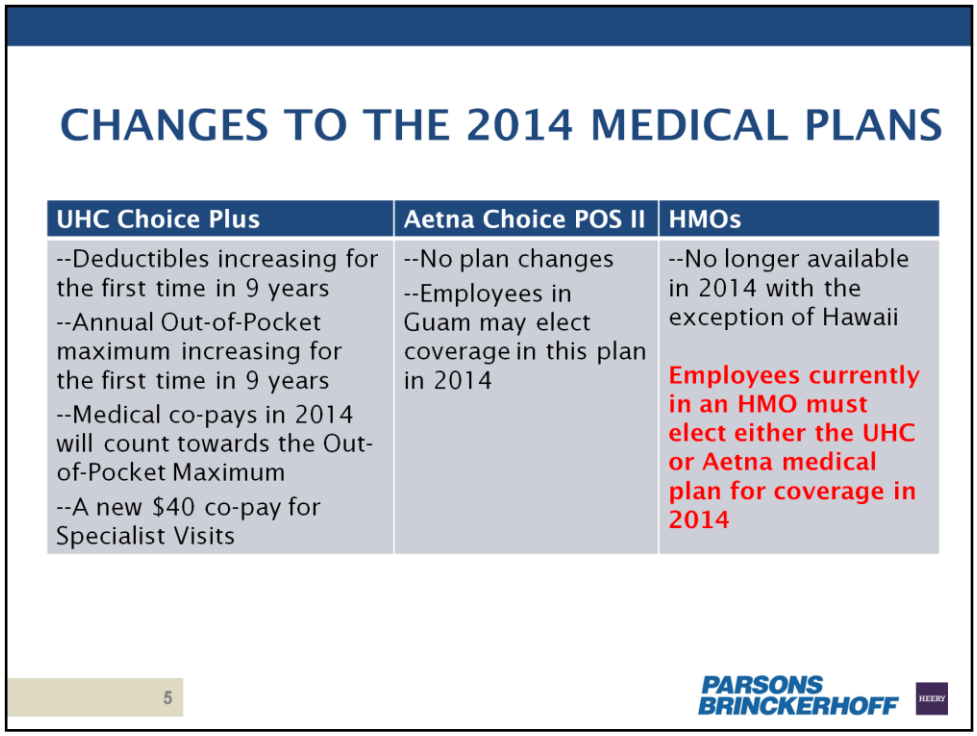
PARSONS BRINCKERHOFF HEERY

Health plans are now required to cover selected preventive care services without cost-sharing as long as these services are provided by network doctors.

In addition, there will be no cost sharing for selected over-the-counter (OTC) medications, which are age- or gender-appropriate, and for contraceptives when prescribed by a doctor and filled at a network pharmacy. For a list of these medications, please visit the United Healthcare or the Aetna websites.

BRCA testing (which tests for the breast cancer susceptibility gene) and genetic counseling to women with a family history of breast cancer will be provided at no cost when using a network provider.

Pregnant and postpartum women will have access to comprehensive lactation support, counseling and breast-feeding equipment in conjunction with each birth, without cost-sharing when received by a network provider.

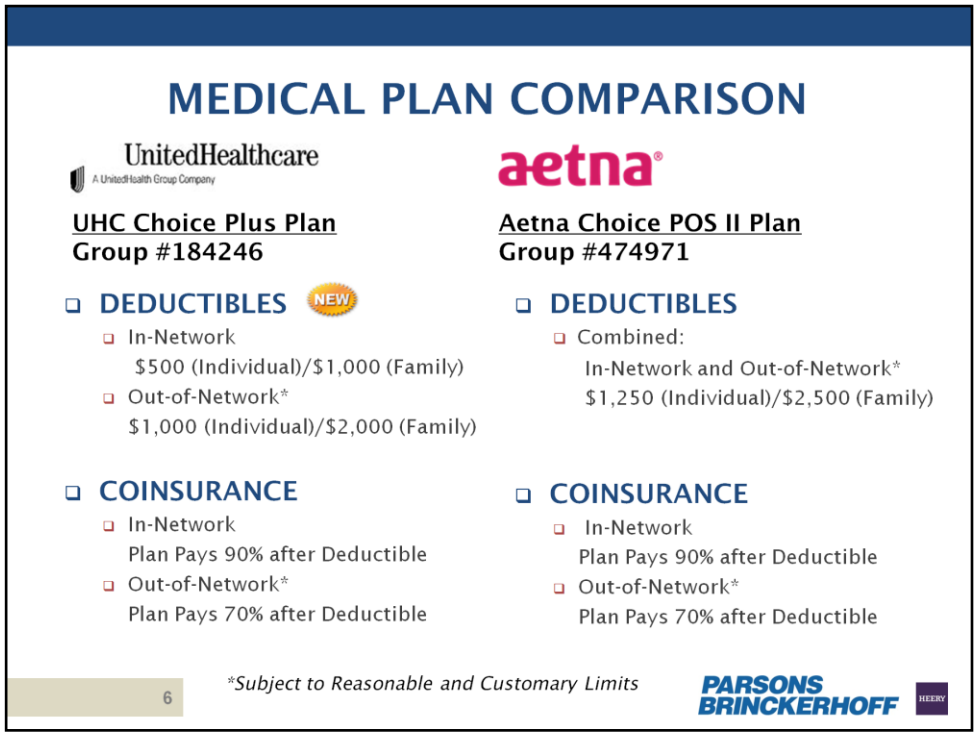


As communicated in 2013, HMOs would be eliminated in 2014 with the exception of Hawaii which is state regulated. Employees currently enrolled in an HMO must elect either the UHC Choice Plus Medical Plan or the Aetna Choice POS II Medical Plan in 2014.

The medical plan names have changed this year to reflect the actual description of the plan. The UHC Choice PPO will now be known as the UHC Choice Plus, and the Aetna Indemnity Plus will be known as Aetna Choice POS II.

There are no changes this year to the Aetna Choice POS II plan deductibles, coinsurance or annual out-of-pocket maximums. However, employees in the Guam office are now eligible to elect coverage in this plan as a medical option in addition to the UHC Out-of-Area Medical Plan.

The changes in the UHC Choice Plus Medical Plan include increases to the deductibles and annual out-of-pocket maximums which have not been increased for 9 years, the addition of a Specialist co-pay and the inclusion of medical co-pays towards the out-of-pocket maximum.



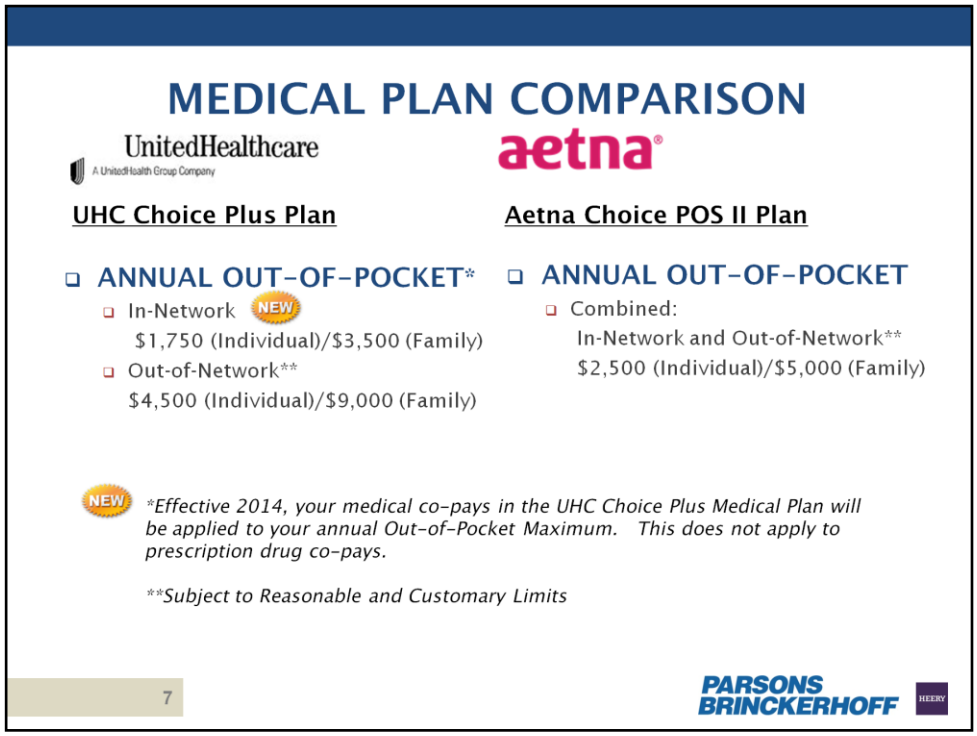
Now let's compare the two medical plans being offered in 2014.

The UHC Choice Plus medical plan has separate deductibles for in-network and out-of-network services, while the Aetna Choice POS II medical plan has a combined deductible that applies to both in-network and out-of-network services.

UHC Choice Plus deductibles for in-network services will be increased from $250 to $500 for individual coverage, and from $500 to $1,000 for family coverage. Out-of-network deductibles will be increased from $500 to $1,000 for individual coverage and from $1,000 to $2,000 for family coverage.

The combined in- and out-of-network deductible for the Aetna Choice POS II medical plan is unchanged from last year - $1,250 for individual coverage and $2,500 for family coverage.

The percentage of coinsurance in both plans remains the same as last year with the plan paying 90% of the costs after the deductible for in-network services and 70% of reasonable and customary costs for out-of-network services.



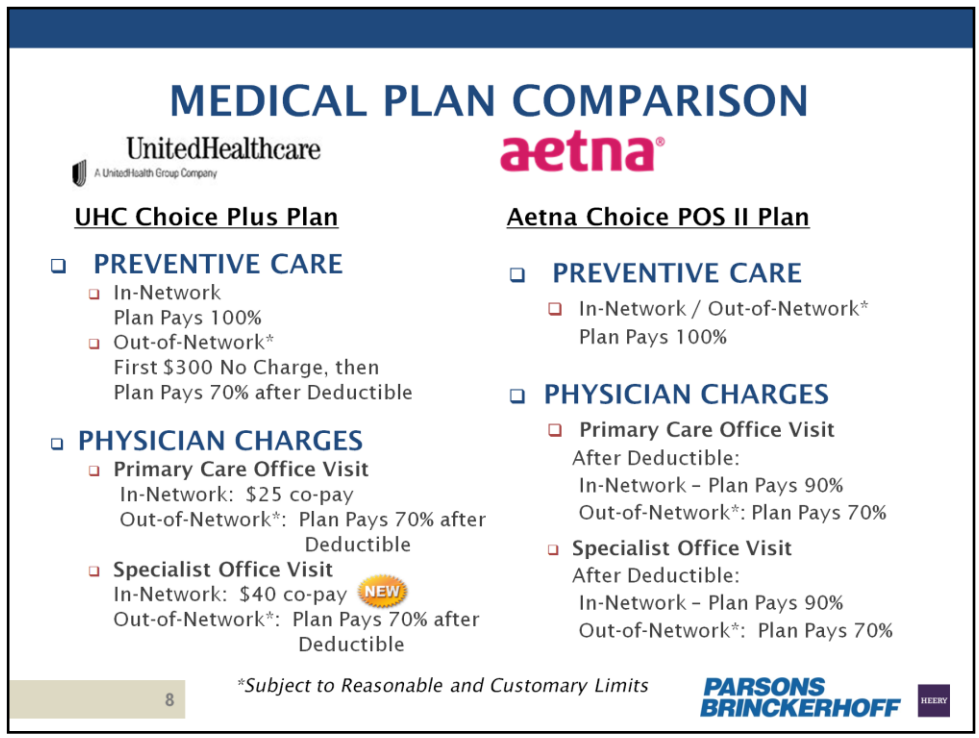
The UHC Choice Plus Medical Plan has two separate out-of-pocket maximums; one for in-network services and the other for out-of-network services. Each maximum has to be satisfied separately. As an example, if you meet the out-of-pocket maximum for in-network services but not for out-of-network services, the plan will cover 100% of eligible in-network expenses for the remainder of the calendar year. You would have to separately satisfy the out-of-pocket maximum for the out-of-network services . Any services which are above the reasonable and customary limits are your responsibility.

The Aetna Choice POS II Medical Plan has a combined out-of-pocket maximum for in-network and out-of-network services. Once this out-of-pocket maximum is reached, the plan would cover 100% of eligibility services for the remaining calendar year; although you are still responsible for any expense that is above reasonable and customary limits for out-of-network services.

Effective 2014, your medical co-pays in the UHC Choice Plus medical plan will be applied to your annual out-of-pocket maximum. This does not apply to prescription drug co-pays.

In the UHC Choice Plus medical plan, the annual out-of-pocket maximums will be increased to $1,750 from $1,250 for individual coverage and to $3,500 from $2,500 for family coverage for in-network maximums. The out-of-network maximums for out-of-network services remains the same at $4,500 for individual coverage and $9,000 for family coverage.

There were no changes to the combined annual out of pocket maximum in the Aetna Choice POS II medical plan. It will remain at $2,500 for individual coverage and $5,000 for family coverage in 2014.



In-network preventive care services are covered at 100% in the UHC Choice Plus plan. Out-of-network preventive care services in the UHC Choice Plus plan will cover the first $300 of preventive services and then 70% of reasonable and customary fees after the deductible has been satisfied. In-network and out-of-network preventive services under the Aetna Choice POS II plan will be paid at 100%.

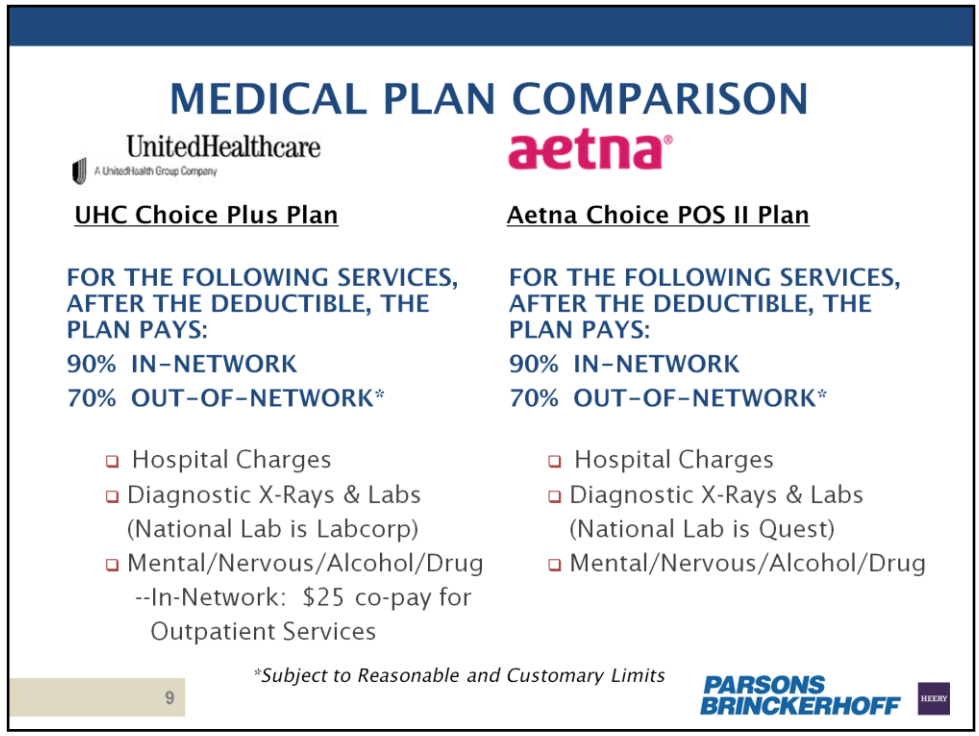
The approach to physician charges is different between these two plans.

The UHC Choice Plus medical plan has a co-pay for office visits. If the visit is to an in-network physician, you are only responsible for the co-pay. If the visit is to an out-of-network physician, you are responsible for 30% after the deductible has been satisfied and any amount above reasonable and customary limits.

The co-pay will be two tiered in 2014; $25 for a primary care office visit and $40 for a Specialist office visit. The Specialist co-pay will not apply to an Internist, a primary care physician , a pediatrician or an OB-GYN.

The Aetna Choice POS II medical plan does not have a co-pay for office visits. Instead, for in-network office visits, either primary care or specialist, the plan covers 90% of the cost after the deductible has been satisfied. You are responsible for the remaining balance.

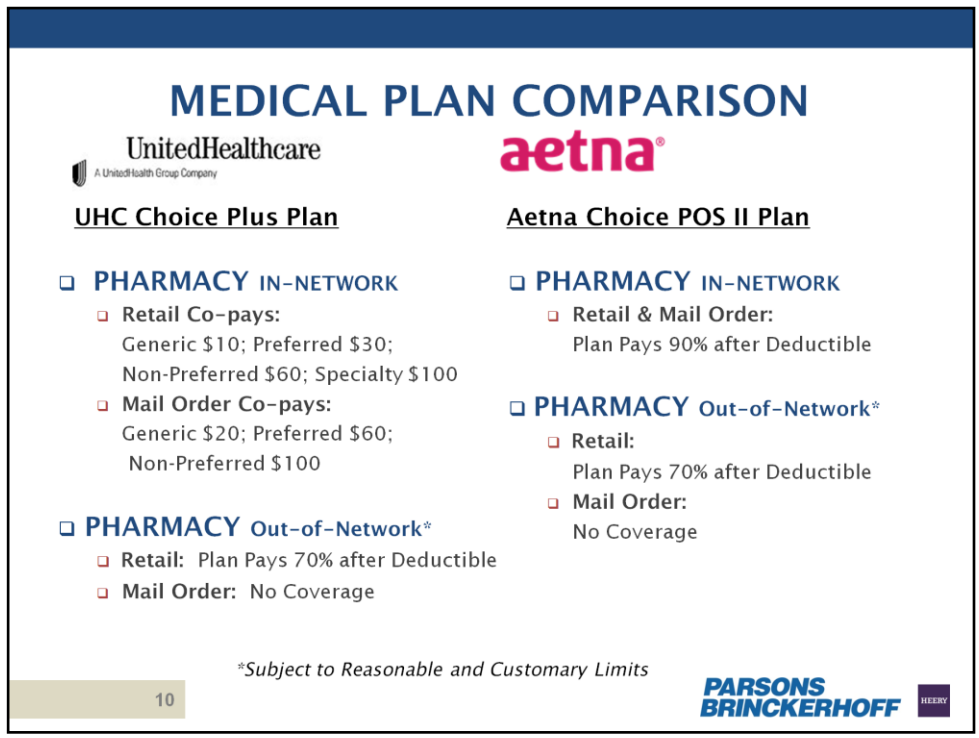
For out-of-network office visits, either primary care or specialist, the plan covers 70% of reasonable and customary costs after the deductible has been satisfied. You are responsible for the remaining balance.



There are no changes in either medical plan for hospital charges, diagnostic x-rays and labs, and mental/nervous/alcohol/drug counseling for in-network or out-of-network services.

Emergency room visits are covered at 90% after the deductible for in- or out-of-network services. There is no coverage for non-emergency use of the emergency rooms.

The preferred national lab for UHC Choice Plus is LabCorp and the preferred national lab for Aetna Choice POS II is Quest.



The pharmacy benefit for both medical plans remains unchanged in 2014.

Due to health care reform, there will be no cost sharing for selected over-the-counter (OTC) medications, which are age- or gender-appropriate, and for contraceptives when prescribed by a doctor and filled at a network pharmacy. For a list of these medications, please visit the United Healthcare or the Aetna websites.

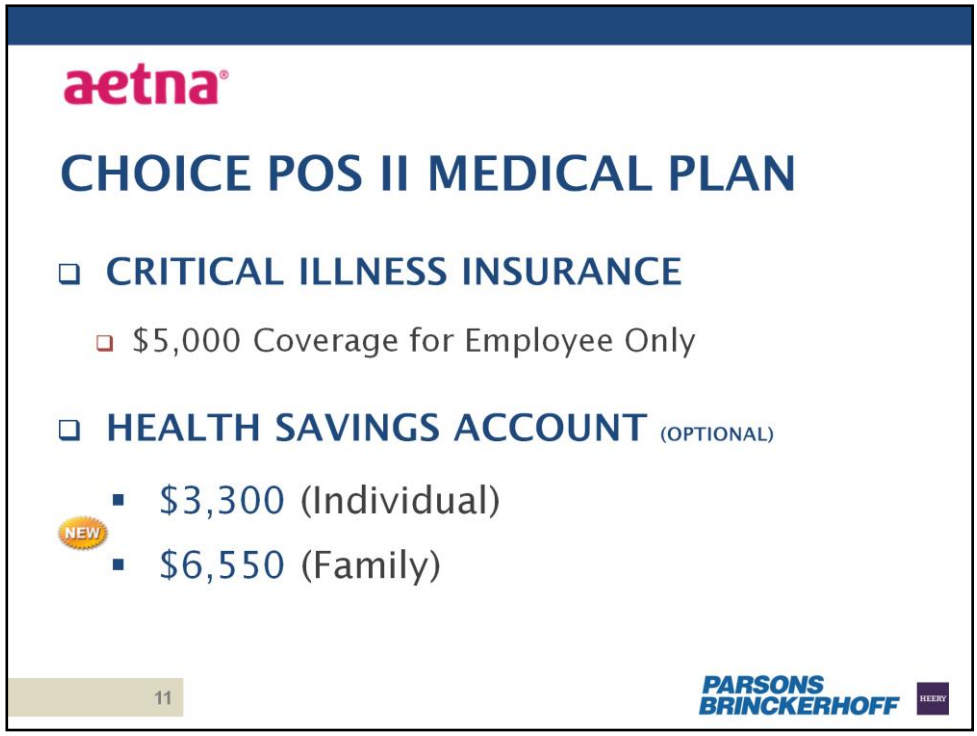
The UHC Choice Plus pharmacy coverage includes tiered co-pays for in-network pharmacy use with co-pays varying based on whether the prescription is generic, preferred, non-preferred or specialty. You are only responsible for the co-pay when using an in-network pharmacy.

There are different co-pays for in-network mail order pharmacy services versus retail. For retail out-of-network pharmacy use, the plan pays 70% of reasonable and customary amounts after the deductible has been satisfied and you are responsible for the balance. There is no out-of-network mail order pharmacy coverage.

The Aetna pharmacy plan does not include a co-pay. For in-network pharmacy use, whether retail or mail order, the plan pays 90% of the cost after the deductible has been satisfied. You are responsible for the remaining balance.

Maintenance medications in the Aetna Choice POS II plan are covered at 90% prior to satisfying the deductible. A list of maintenance medications is posted on the 360 site, Human Resources, Benefits.

For out-of-network, there is only a retail option – no coverage at all for out-of-network mail order pharmacy use. For out-of-network retail pharmacy use, the plan will cover 70% of reasonable and customary costs after the deductible has been satisfied and you will be responsible for the remaining balance.

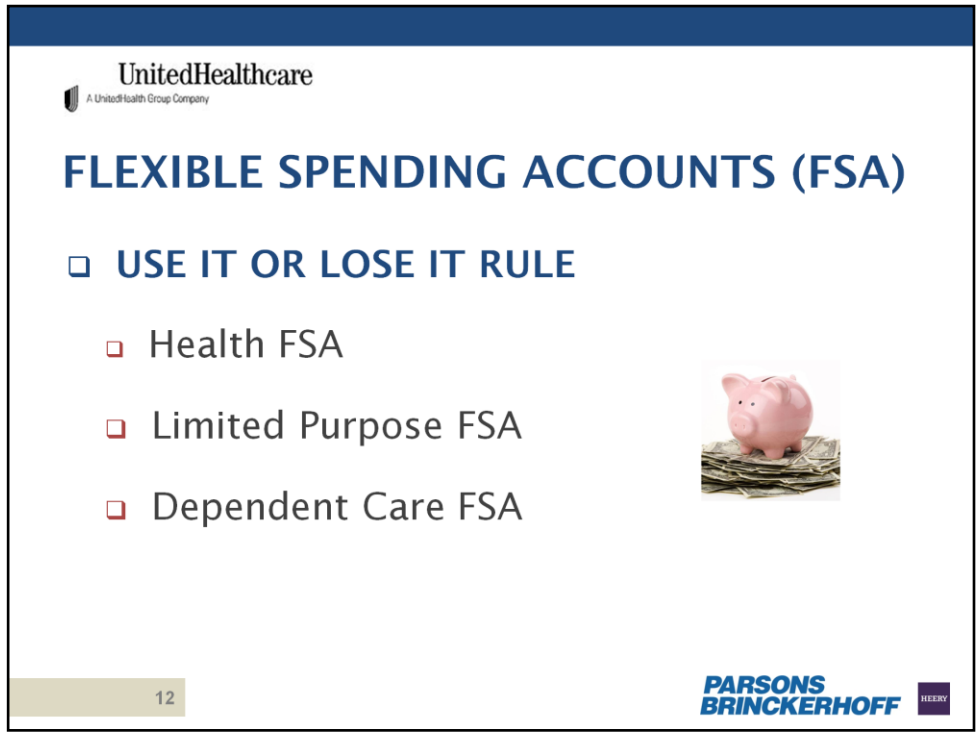


There are other differences between these two medical plans.

Employees who elect the Aetna Choice POS II medical plan will automatically be covered by a $5,000 Critical Illness insurance policy. This coverage is provided for the employee only, regardless if they include dependents in their coverage election. This policy is provided at no cost to the employee and covers expenses the employee may incur if they have a critical illness as outlined by the policy. Please note that employees are able to elect additional Critical Illness coverage through the Voluntary Lifetime Benefits enrollment.

A Health Savings Account is only available to Aetna Choice POS II participants to save pre-tax dollars to help offset qualified medical, dental and vision expenses. This bank account is set-up with JP Morgan Chase. Money in this account earns tax-free interest and when used for qualified expenses is also tax free. Contribution amounts have been increased for 2014 per federal guidelines.

The Health Savings Account requires annual elections and you are permitted to make changes to the contribution amount throughout the year without experiencing a qualified life event. And best of all, this is not a "use it or lose it" account. The balances carry over year to year and is your account to take with you to cover qualified medical, dental or vision expenses if you terminate or retire from the company.



The carrier for all the flexible spending accounts is United Healthcare.

Flexible spending accounts allow you to set aside pre-tax dollars to pay for qualified incurred healthcare and dependent care expenses. There are three types of flexible spending accounts:

Health FSA

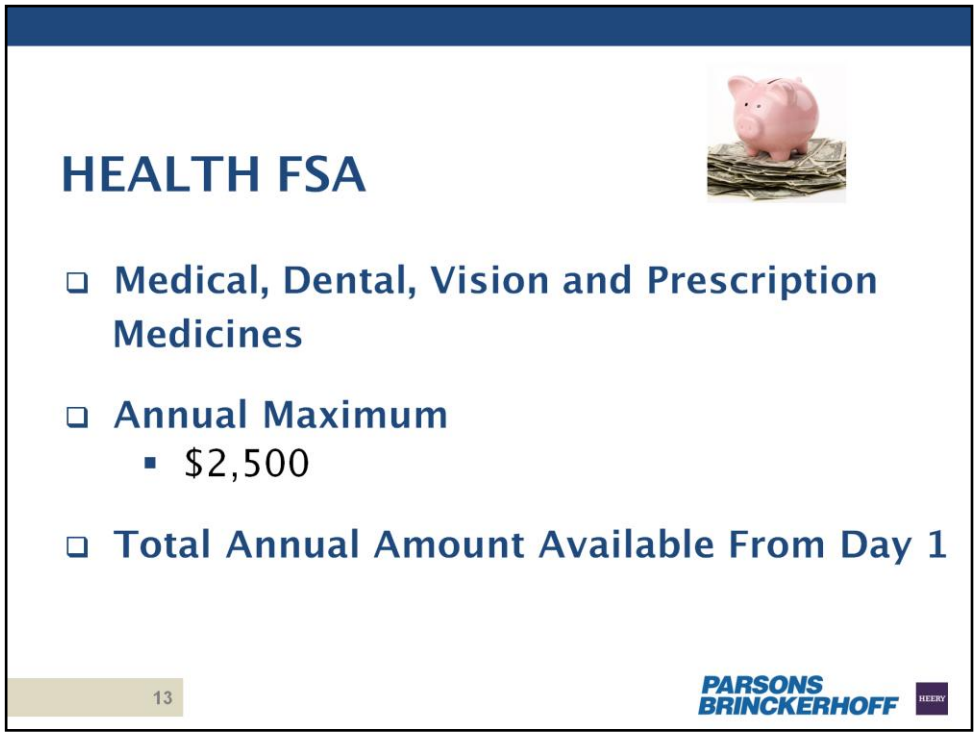
Limited Purpose FSA

Dependent Care FSA

Each type of FSA is intended to help you offset different qualified expenses and annual elections are required for participation in each FSA every year.

The most important point to keep in mind is that IRS regulations require the forfeiture of unclaimed monies remaining in a flexible spending account. FSA money cannot be refunded, transferred to another account or rolled over to the following year.

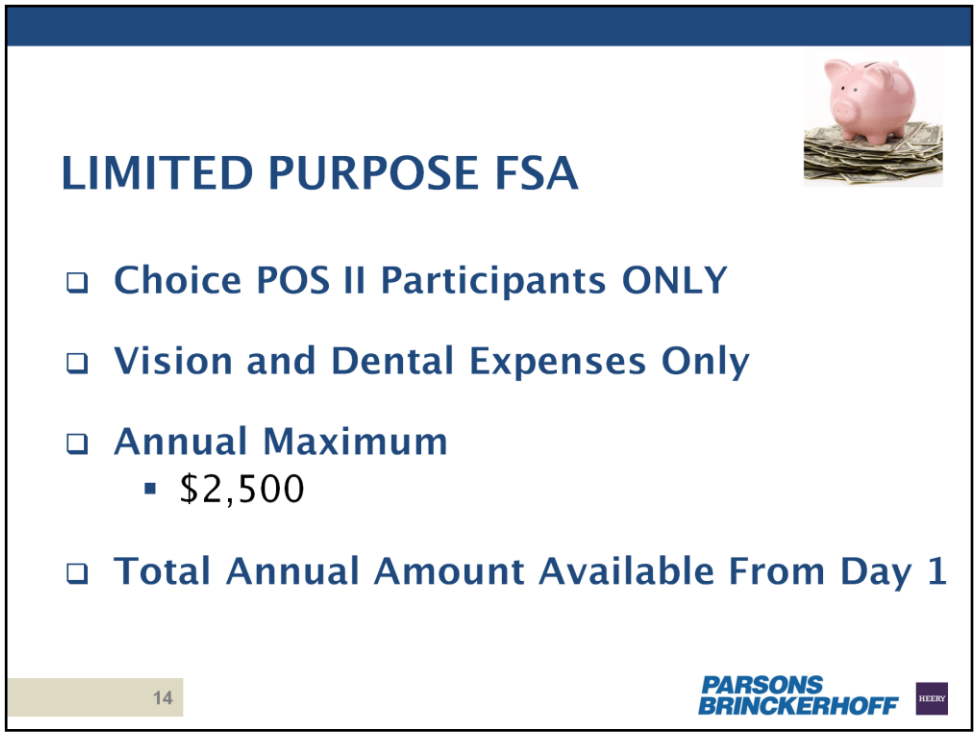
You have until April 30th of the following year to file for reimbursement of healthcare or dependent care expenses incurred during the calendar year you were enrolled.



The Health Flexible Spending Account is available to you if you are enrolled in the UHC Choice Plus medical plan, an HMO, or in another health plan outside of the Company.

It is intended to help you pay for medical, dental, vision and prescription medicine expenses not paid by your health plans.

The maximum amount you can contribute to a Health FSA is $2,500 and the total amount you elect is available from Day 1 regardless of what you have contributed.



If you are enrolled in Aetna Choice POS II medical plan, you can only participate in the Limited Purpose flexible spending account. This spending account reimburses you for eligible vision and dental expenses not paid by your vision and dental plans.

The maximum amount you can contribute to the Limited Purpose FSA is $2,500. The total amount you elect is available from Day 1 regardless of what you have contributed.

The Dependent care flexible spending account helps to pay for eligible day care expenses including after school programs and adult day care facilities for working families. Dependent care expenses must be related to care or services provided to children under the age of 13 or tax dependents that are mentally or physically incapable of self-care.

Per IRS regulations, married couples can only claim up to $5,000 per household in dependent care expenses.

MetLife

BASIC DENTAL PLAN

- PREVENTIVE SERVICES ONLY
  - Two Cleanings per Year
  - Two Oral Examinations per Year
  - X-Rays

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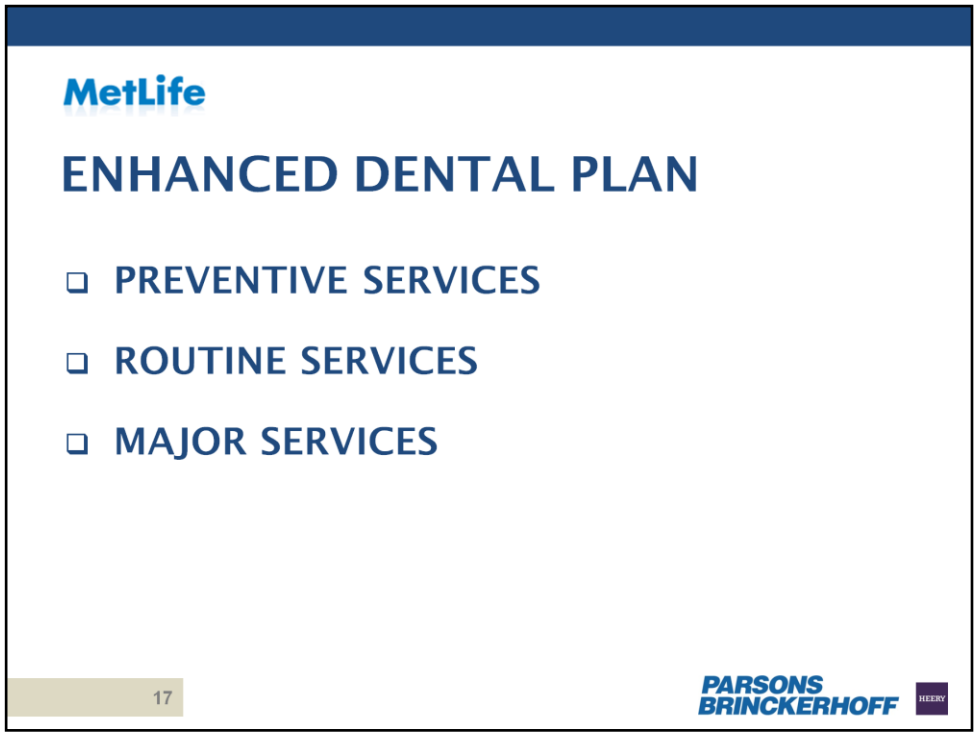
PARSONS BRINCKERHOFF HEERY

Let's review the dental plans in 2014…

MetLife is the dental carrier for Parsons Brinckerhoff. The Basic dental plan offers low cost basic dental care. The plan provides 100% coverage for preventive dental services such as oral exams and cleanings, twice a calendar year, if using an in-network dentist. Preventive services are subject to reasonable and customary limits if you utilize an out-of-network dentist.

There is no coverage for services other than preventive care in this dental plan.

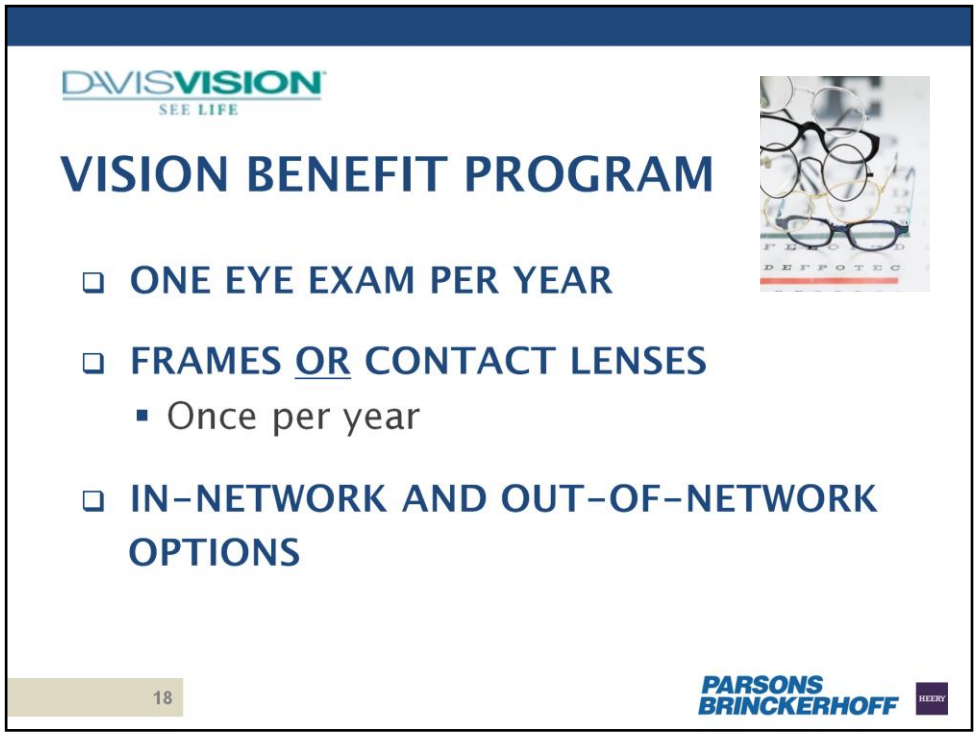


The Enhanced dental plan is a comprehensive program in which certain preventive, routine and major dental services and supplies are covered.

Child orthodontia is available in the Enhanced plan, all other years. The orthodontia lifetime maximum per dependent is $1,500.

There is a $50 deductible on routine and major services. The annual maximum benefit per individual is $1,500.

Coverage for First Year participants is reduced. See A Bridge to Health Benefits Guide for more information.



Davis Vision remains the vision carrier for 2014 with in-network and out-of-network options. Vision benefits include an eye exam and frames or contact lenses once every year. Additional vision benefits are detailed in the Davis Vision Summary of Benefits.

To locate a vision provider, go to www.davisvision.com, select "Members" and enter the control code 7249 under the "Open Enrollment" box.

The Davis Vision Affinity Discount Program provides savings on professional services and eyewear at no additional cost to any benefit-eligible employee regardless of whether they elected to participate in the Vision Benefit Program. To be eligible for this discount, the employee must use a Davis Vision provider and inform the provider they have the Davis Vision Affinity Plan through Balfour Beatty/Parsons Brinckerhoff. The discount is applied at the time of service, thus eliminating the need for claim forms.

To locate a vision provider, go to www.davisvision.com and enter the control code 7251. To view the Affinity Discount Program benefits, go to 360, Human Resources, Benefits, and click on "VISION" .

Liberty Mutual is the disability carrier for short-term and long-term disability. Short-term disability is provided by the Company at no cost to the employee and provides a 60% weekly benefit (up to $1,200) should the employee become disabled due to a non-occupational illness or injury.

Long-term disability is an optional benefit which the employee may elect and offers two coverage options: Basic LTD with a benefit of 50% monthly salary up to $7,500; and Enhanced LTD with a benefit of 60% monthly salary up to $15,000.

There were no changes in the plan design for short- or long-term disability.

For more information on your disability benefits or how to file a claim, refer to the benefits guide, A Bridge to Health or go to the 360 site, Human Resources, Benefits.

The following Core Benefits are provided by the Company:

The Basic Life Insurance coverage maximum is one times annual salary up to $500,000.

Accidental Death & Dismemberment Insurance coverage maximum is also one times annual salary up to $500,000.

The maximum coverage for Business Travel Accident Insurance is five times annual salary up to $500,000 for employees making over $50,000 per year. Employees making under $50,000 have a maximum coverage of five time annual salary up to $250,000.

Open Enrollment is a good time to review your beneficiaries on file for these insurances to make sure they reflect your wishes.

2014 PREMIUMS

- MEDICAL PLANS
- DENTAL PLANS
- VISION PLANS
- LONG-TERM DISABILITY

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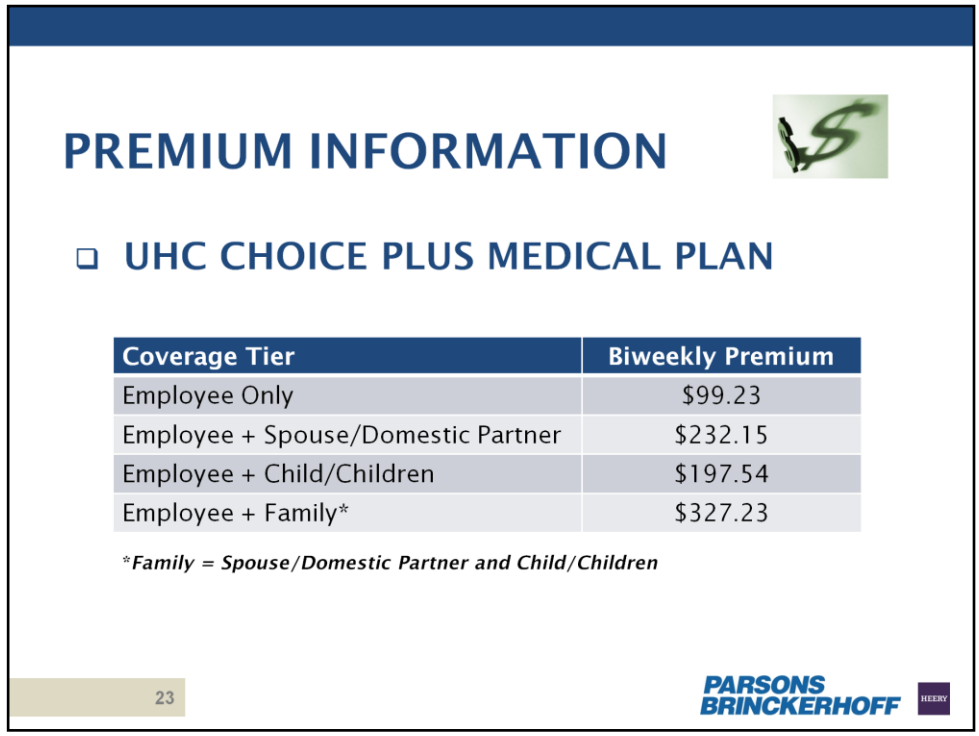
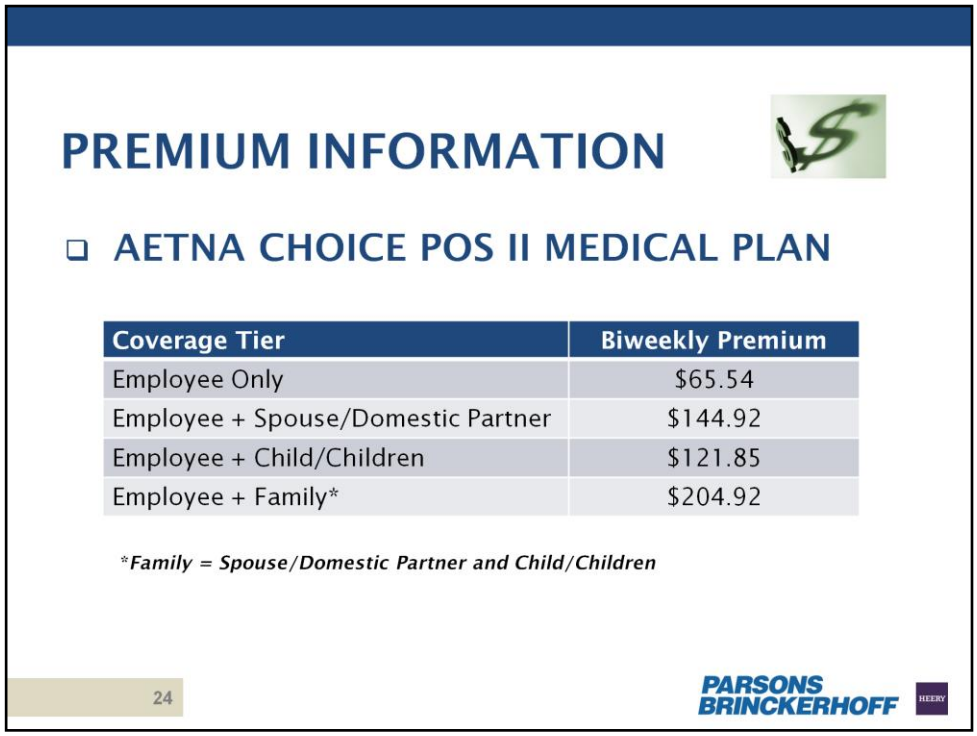
PARSONS BRINCKERHOFF HEERY

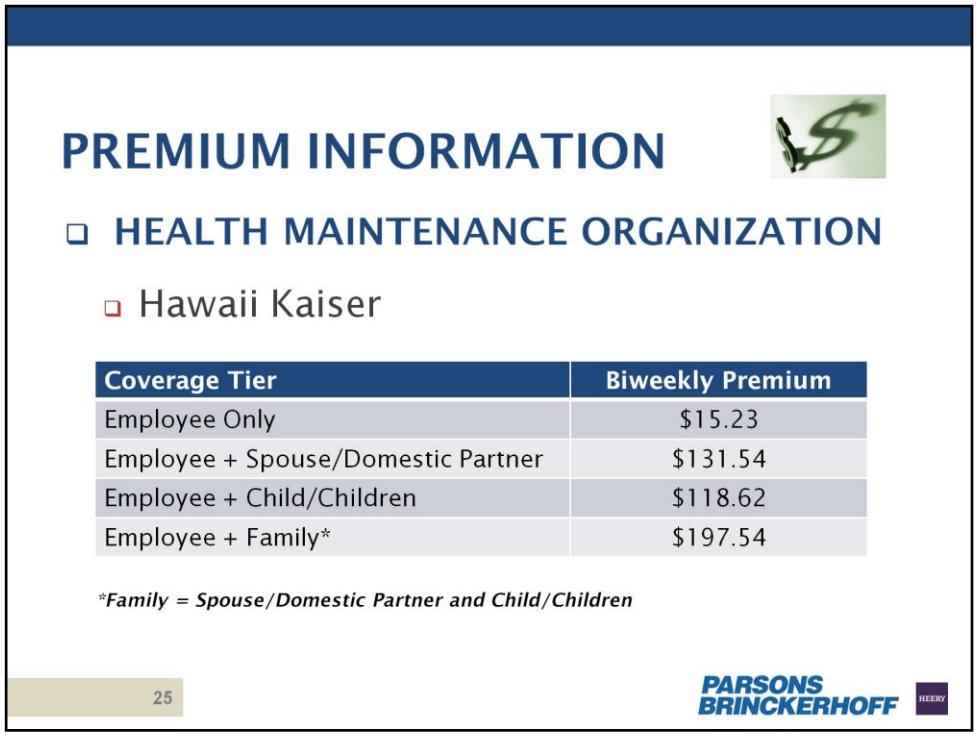
Next we will review the 2014 premiums for the medical, dental, vision and long-term disability plans.



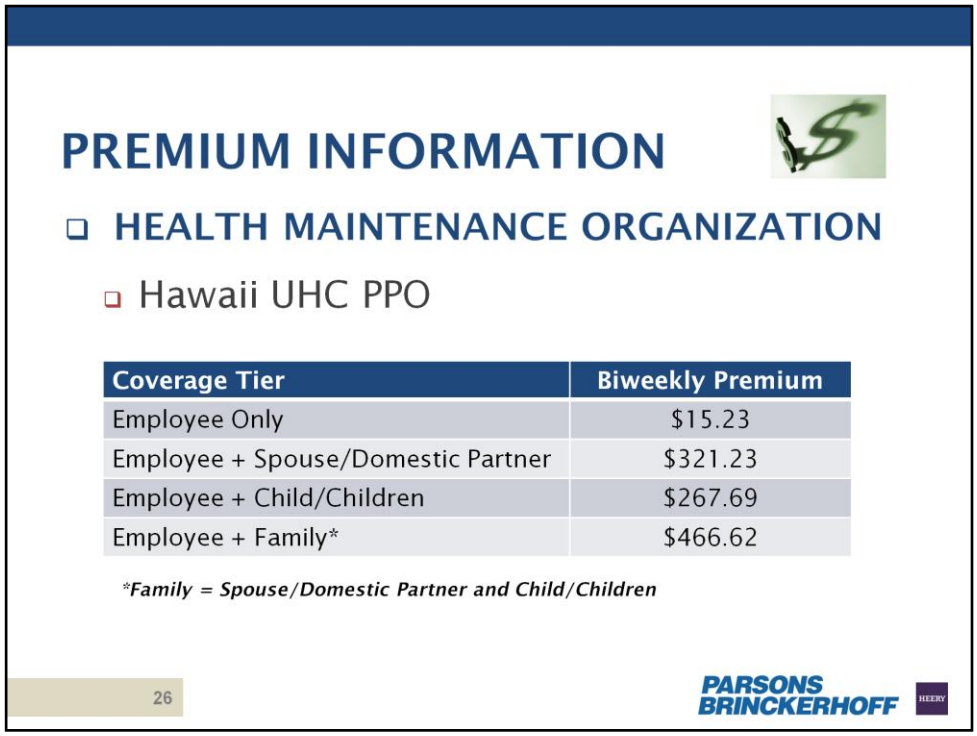
The new premium structure for 2014 for the UHC Choice Plus medical plan is displayed on the slide.



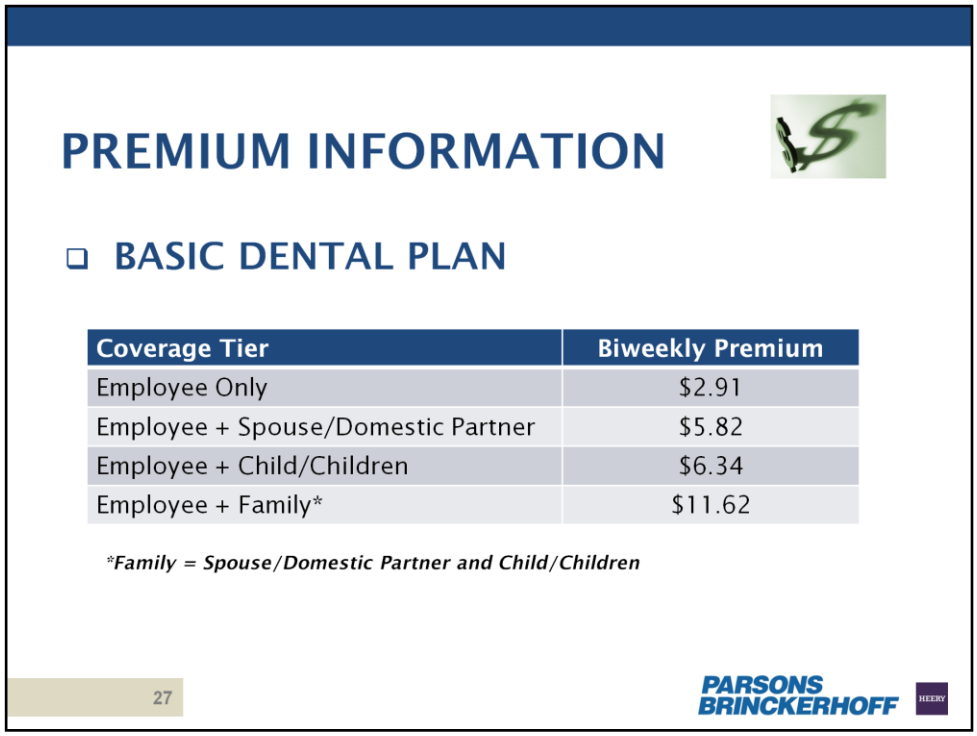
The 2014 biweekly employee contributions for the Aetna Choice POS II medical plan are displayed on the slide.



The Hawaii Kaiser HMO premiums for 2014 are displayed on the slide.



Here are the Hawaii UHC PPO medical plan biweekly costs for 2014.



There will be **no** increase to the biweekly employee contributions for the Basic Dental plan in 2014.

PREMIUM INFORMATION

ENHANCED DENTAL PLAN

Coverage Tier	Biweekly Premium
Employee Only	$9.44
Employee + Spouse/Domestic Partner	$17.32
Employee + Child/Children	$18.85
Employee + Family*	$30.59

**Family = Spouse/Domestic Partner and Child/Children*

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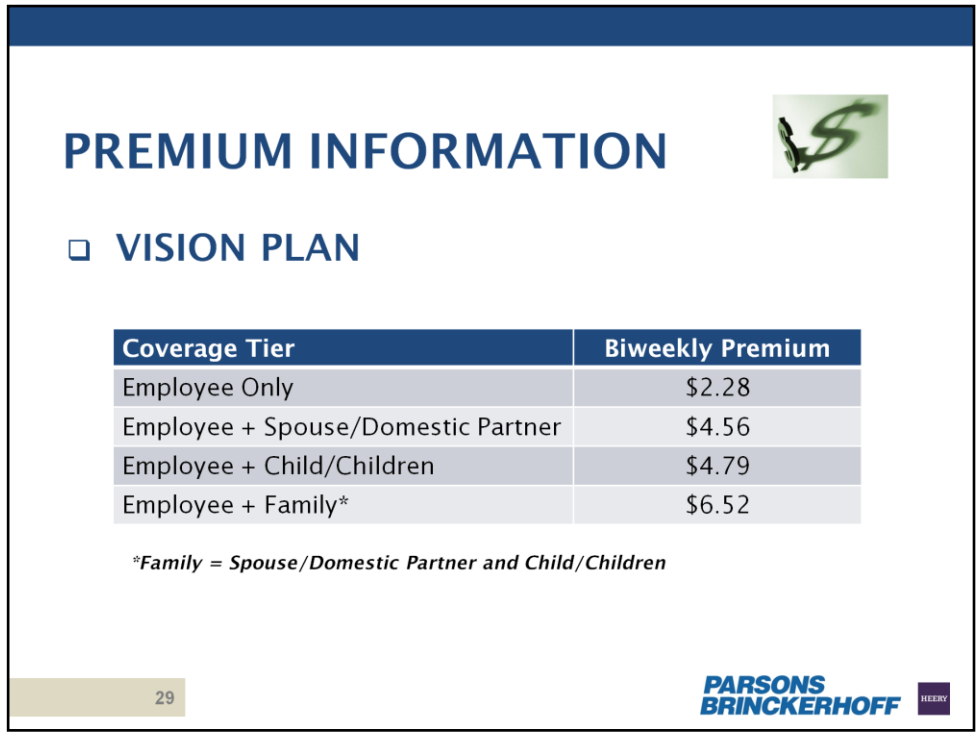
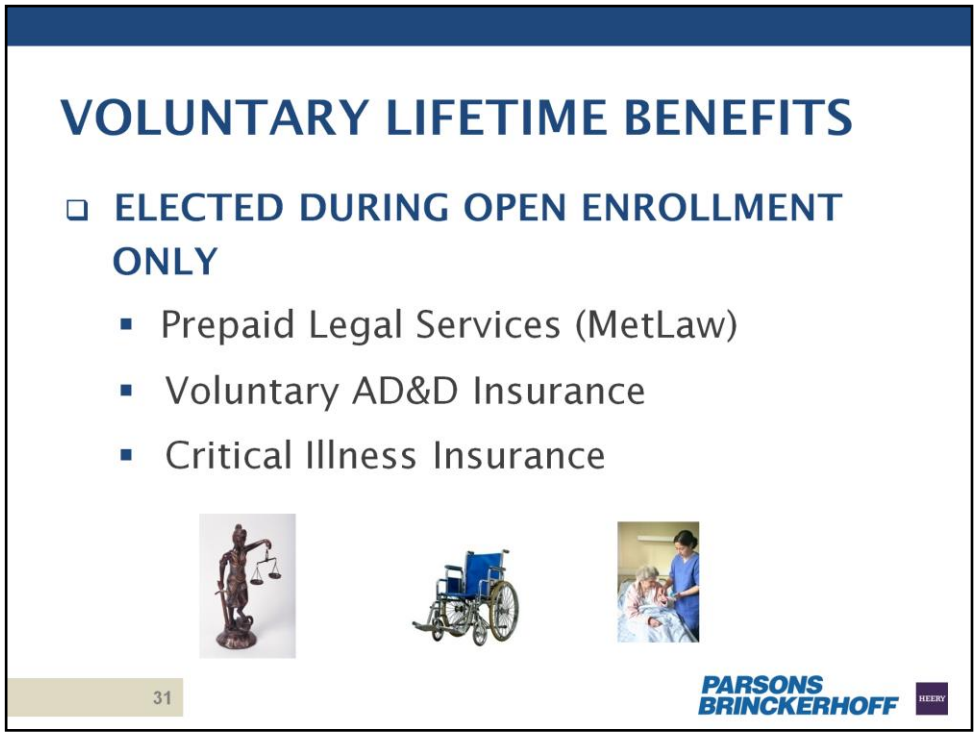
PARSONS BRINCKERHOFF HEERY

In addition, there will be **no** increase to the biweekly employee contributions for the Enhanced Dental plan in 2014.



There will be **no** changes to the vision employee contributions in 2014.

The slide shows the premium rates and calculation for long-term disability insurance for 2014. There is **no** cost increase in these premiums for 2014.



The voluntary Lifetime Benefits Open Enrollment period will run concurrently with the Benefits Open Enrollment Period and will begin October 24th and continue through November 7th.

Parsons Brinckerhoff offers a variety of voluntary lifetime benefits. Some require election during the annual benefits open enrollment period; others can be elected throughout the year.

These voluntary benefits must be elected as part of the benefits open enrollment process:

Prepaid Legal Services (also known as MetLaw),

Voluntary Accidental Death and Dismemberment Insurance, and

Critical Illness Insurance.

As noted earlier in the presentation, a critical illness policy is given automatically to those employees who elect the Aetna Choice POS II medical plan and it covers the employee only – not dependents. These employees can chose to purchase additional coverage or policies for themselves and their dependents in this plan.

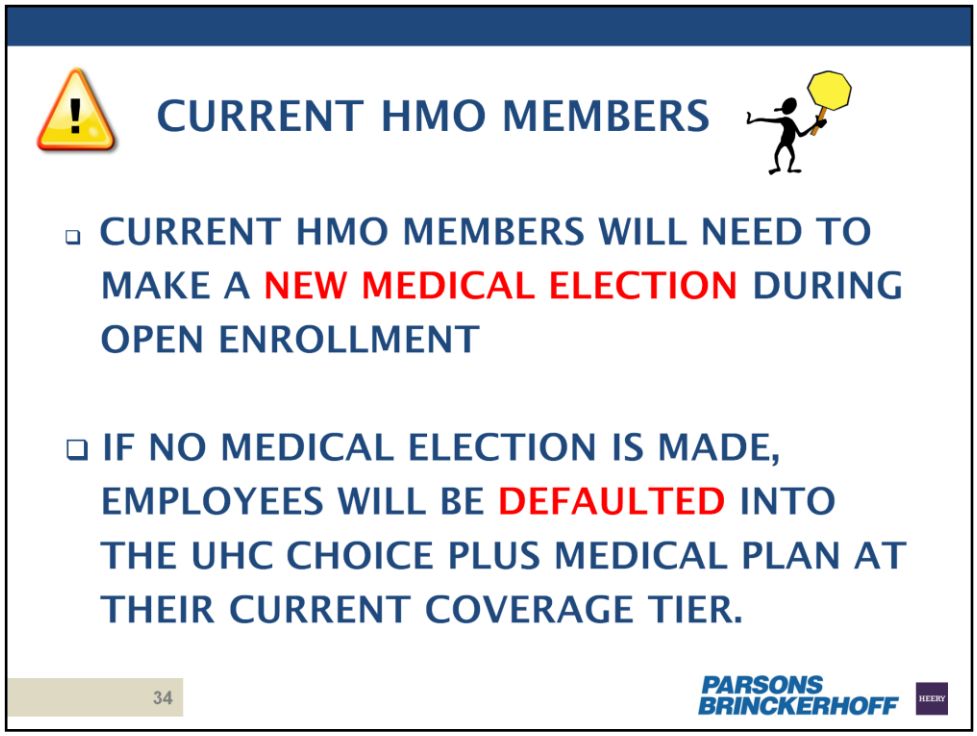
Enrollment in Supplemental and Dependent Life Insurance, Auto & Home Insurance and Veterinary Pet Insurance is available throughout the year.

You must contact the carrier directly for enrollment in these voluntary benefits. Refer to the Voluntary Lifetime Benefits section of the Benefits Guide, A Bridge to Health, for contact information.

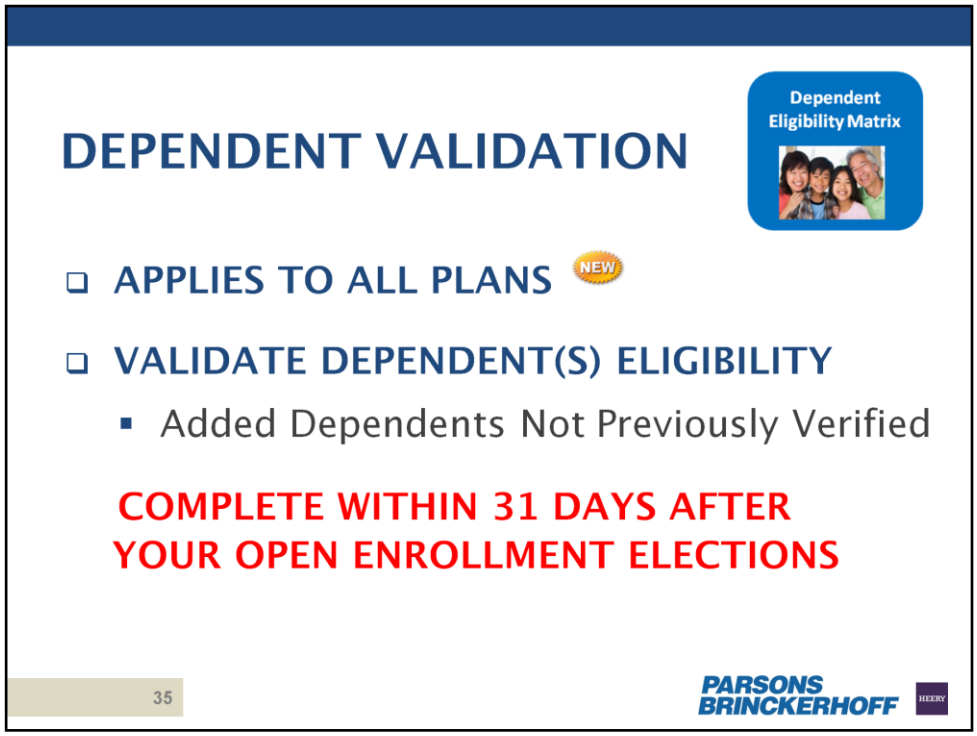
Open Enrollment begins on October 24th and ends on November 7th. We encourage you to mark these dates on your calendar and make your benefit selections in a timely manner.

Beginning October 24th, you can make your 2014 benefit elections via the benefits website which is available 24/7 or by calling the Employee Benefits Service Center at 1-877-723-5399, weekdays from 9:00 am to 6:00 pm Eastern Time.

Log-on instructions for the benefits website are located on 360, Human Resources, Benefits, click on the OPEN ENROLLMENT icon.



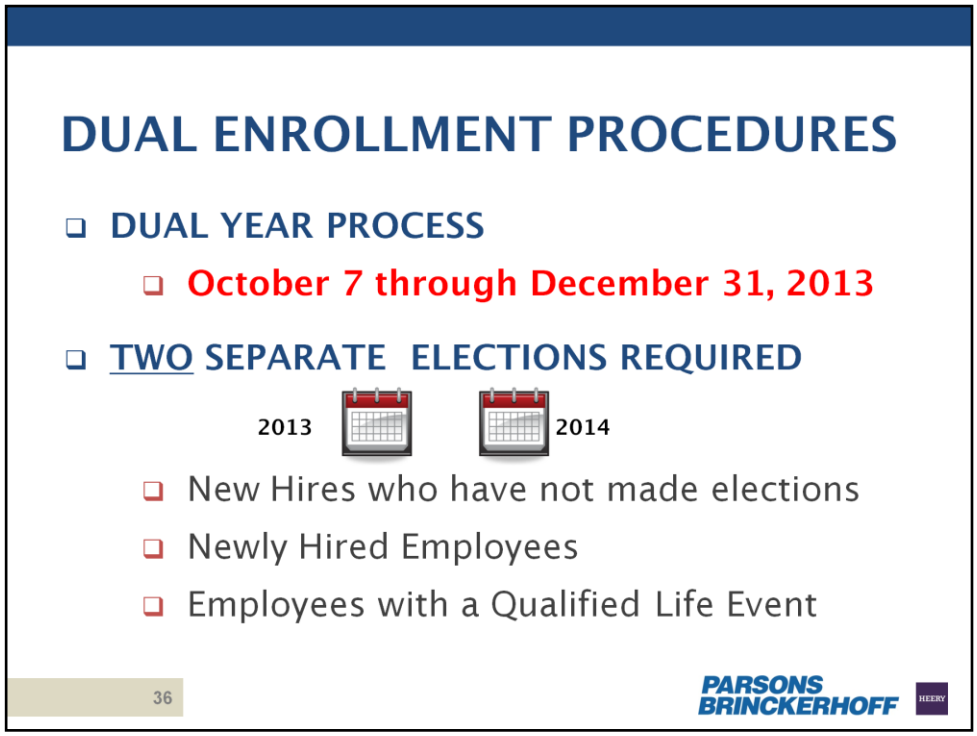
As mentioned earlier, if you are currently enrolled in a HMO medical plan, you must make a **new** medical election during Open Enrollment. Otherwise, you will be defaulted into the UHC Choice Plus Medical Plan at the same coverage tier level in which you are currently enrolled.



Effective 2014, if you enroll dependents who were not previously verified under any medical, dental or vision plan during Open Enrollment, you will be required to provide proof of dependent eligibility within 31 days from your Open Enrollment elections in order to complete the dependent enrollment process.

Documents required for dependent validation, along with submittal information, are detailed on the Dependent Eligibility Matrix in the benefits guide, A Bridge to Health.

If you do not submit the required documentation with 31 days of making your open enrollment elections, coverage for your dependent(s) will be dropped for the 2014 plan year.



The dual year process begins on October 7, 2013 and continues through December 31, 2013.

All new hires who have not made benefit elections by October 7th must make two separate benefit elections – one for 2013 and another for 2014.

All individuals hired on or after October 7th must make two separate benefit elections – one for 2013 and another for 2014.

Employees who experience a qualifying life event on or after October 7th will also be required to make two separate elections as the changes they make in 2013 will not roll over to 2014. Also if an employee opened a qualified life event that has not been completed prior to October 7th, they will have to make two elections.

Once an employee completes their 2013 elections, they will be prompted to make 2014 elections. Please take this action immediately after completing your 2013 elections.

SUCCESSFUL OPEN ENROLLMENT TIPS

- CHECK YOUR COMPANY E-MAIL AND HOME MAILBOX REGULARLY
- REVIEW YOUR CONFIRMATION STATEMENT

- MAKE CORRECTIONS DURING THE CHANGE PERIOD
  - November 18 through November 22

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PARSONS BRINCKERHOFF

The following tips will help ensure you have a successful Open Enrollment period.

Check your company e-mail and home mailbox regularly for Open Enrollment materials.

Review your confirmation statement. This statement reflects your 2014 benefits. If there is a problem, correct it during the Change Period or if you are outside the Change Period, report it to the Employee Benefits Services Center at 1-877-723-5399 weekdays between 9:00 am and 6:00 pm Eastern Time.

During the Change Period, make any corrections or if you missed the original Open Enrollment period you can make elections at this time. The Change Period runs from November 18th through November 22nd. This is the **last** opportunity to make changes to your benefits for 2014.

Check your first pay stub in 2014 to confirm your deductions are correct and, if not, report problems immediately to your HR manager or administrator.

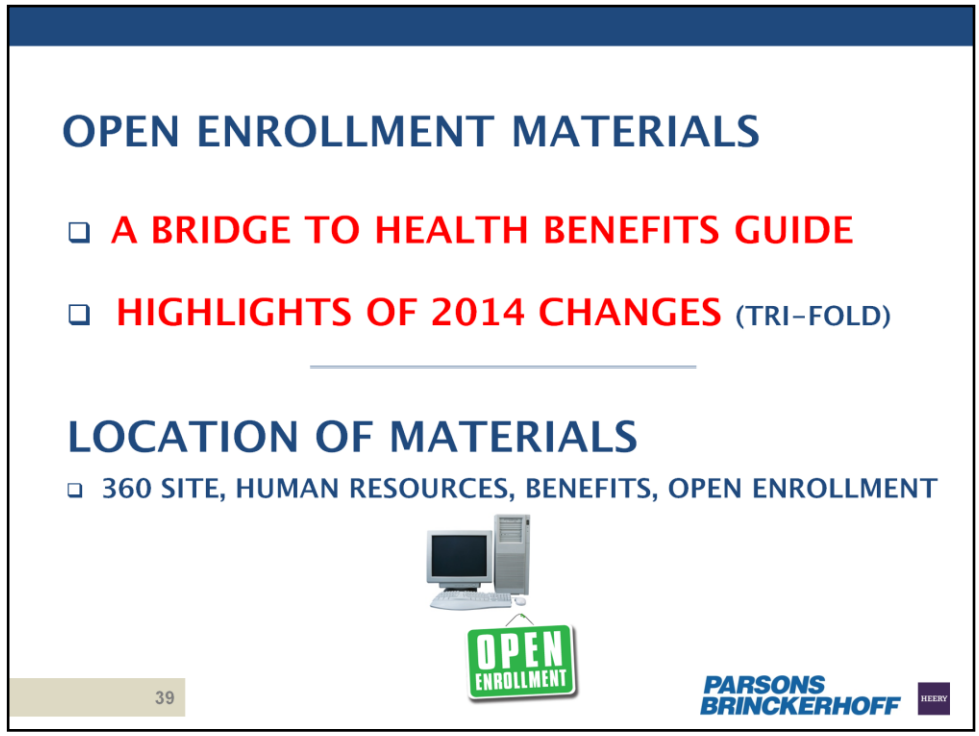
The Dual Enrollment Period runs from October 7th through December 31st. Any new hire who has not made benefit elections prior to October 7th or any employee hired on or after October 7th, or any employee who experiences a qualified life event on or after October 7th or has not completed an open qualified life event prior to October 7th will need to make two separate benefits elections – one for 2013 benefits and the other for 2014 benefits. Your 2013 benefit elections will not roll over to 2014 unless you make the separate election.

Some other tips during Open Enrollment include:

Verify your dependents still meet eligibility requirements outlined in the Dependent Eligibility Matrix in the Benefits Guide, A Bridge to Health.

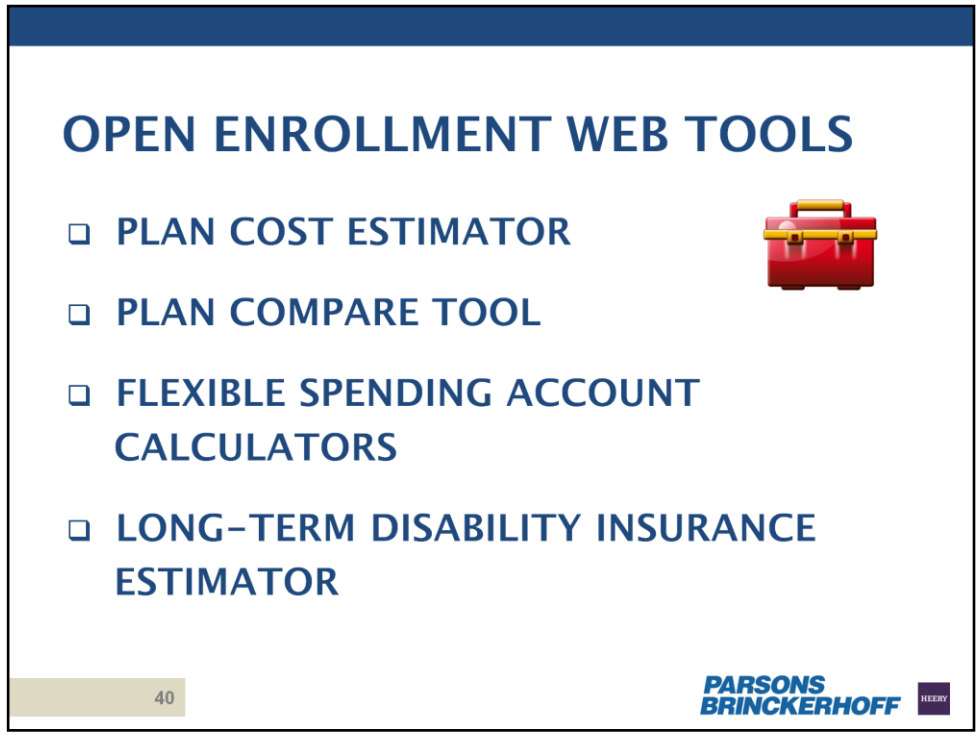
Review your beneficiary information for your company provided insurances (Basic Life, AD&D and Business Travel Accident) to make sure it reflects your wishes.

After you have completed your benefits enrollment, take a moment to review your voluntary lifetime benefits options.



A Bridge to Health Benefits Guide and Highlights of 2014 Changes tri-fold was mailed to employees' homes the week of October 14th.

If you did not receive these documents, you can download a copy of Open Enrollment materials from 360, Human Resources, Benefits, click on the Open Enrollment icon.



Online planning tools are available on the Employee Benefits Service Center website to help you make informed healthcare decisions.

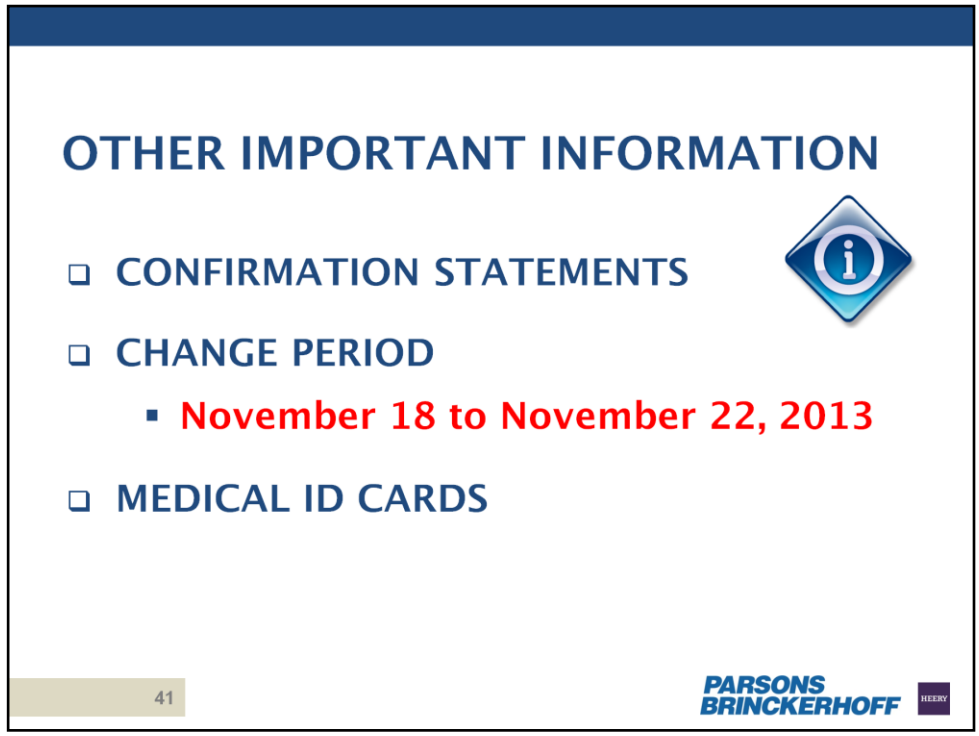
The Plan Cost Estimator allows you to compare plans and enter anticipated medical costs which will determine your out-of-pocket costs in each plan.

The Plan Compare Tool allows you to view up to three plans side-by-side to compare plan design such as deductibles, coinsurance, co-payments, etc.

There are two flexible spending account calculators – one for health expenses and the other for dependent care expenses. These calculators help you determine how much to set aside in your FSA. Per IRS regulations, married couples can only claim up to $5,000 in dependent care FSA expenses.

The LTD Insurance Estimator determines which coverage level is appropriate for you based on your estimated needs and costs.

Please take advantage of these valuable tools.



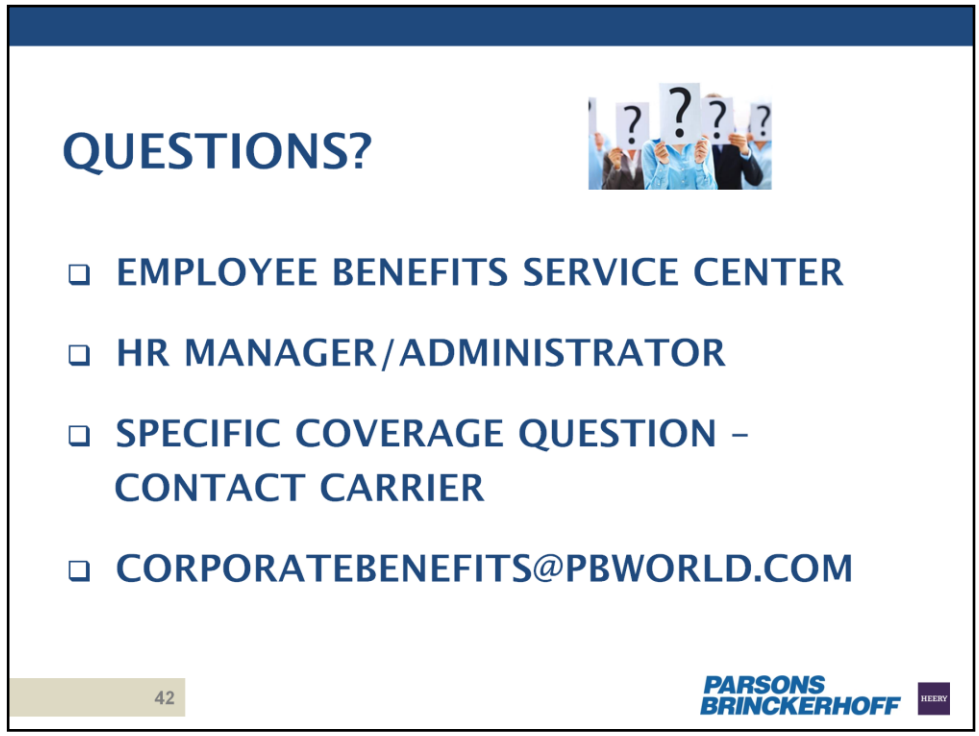
There are a few special items to keep in mind during Open Enrollment:

Confirmation statements will be mailed November 14, 2013. Please take the time to review your confirmation statement for accuracy. If there is an error, you will need to make the correction during the Change Period.

The Change Period will be from November 18 through November 22, 2013. During the Change Period you are able to make adjustments to your enrollment. Another confirmation statement will be generated for any changes made during the Change Period. Please review this statement carefully. You will not receive another confirmation statement if you did not make changes during this period.

The Change Period does not apply to the Voluntary Lifetime Benefits.

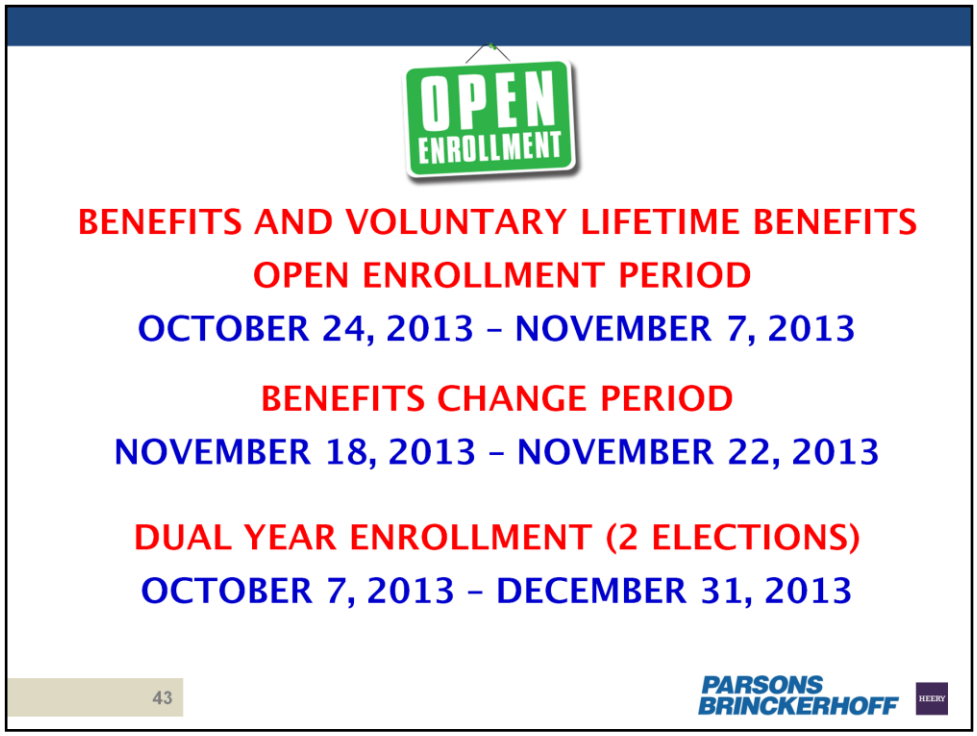
If you elected a new medical plan, you should receive your medical ID cards by the end of December. Also all UHC Choice Plus members will receive new ID cards as a result of the plan design changes being implemented in 2014.



Contact the Employee Benefits Service Center at 1-877-723-5399 weekdays between 9:00 am and 6:00 pm Eastern Time or your HR Manager or local HR administrator if you have any questions regarding Open Enrollment.

For coverage questions about specific procedures, call the insurance carrier directly. Contact numbers are in the benefits guide, A Bridge to Health.

You may also email your questions to the Corporate Benefits email box.

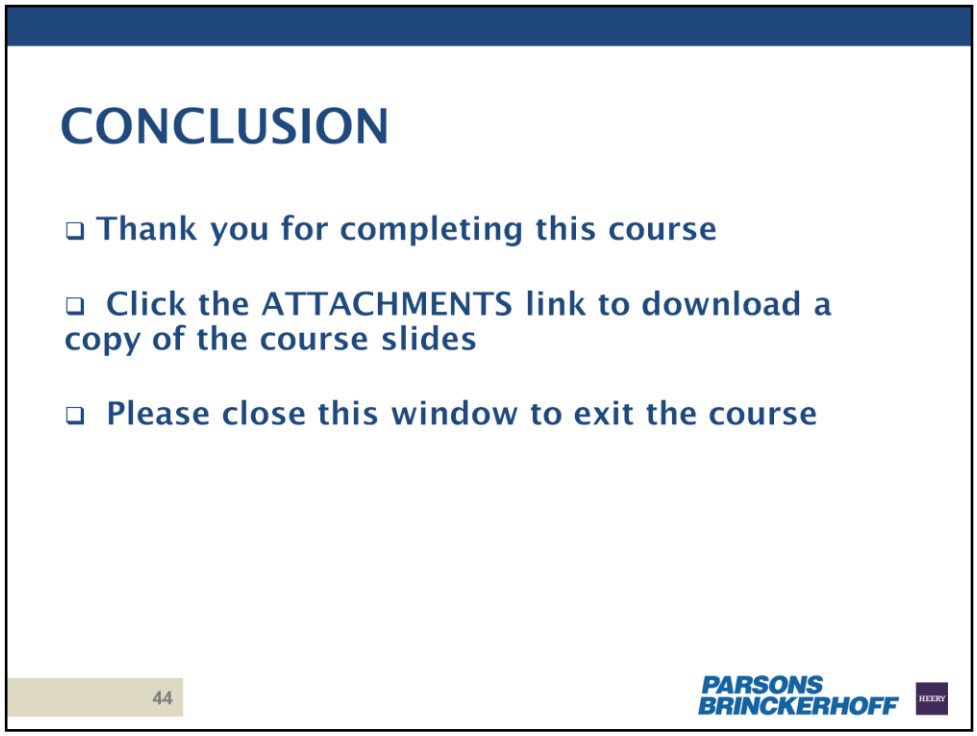


In summary, October 24th through November 7th will be the Benefits Open Enrollment period and the voluntary Lifetime Benefits Open Enrollment period. You can make benefits elections/changes for 2014 via the Employee Benefits Service Center website or by calling 1-877-723-5399 weekdays between 9:00 am and 6:00 pm Eastern Time.

Prepaid Legal Services, Voluntary AD&D Insurance, and Critical Illness Insurance can be elected through the Employee Benefits Service Center at the same time you make your benefits elections. You must contact the carrier directly for enrollment in all other voluntary benefits. Refer to the Benefits Guide, A Bridge to Health, for contact information.

The dual year enrollment period will be from October 7th through December 31st. During this period new hires or newly eligible employees and those who experience a qualified life event, will need to make two benefit elections – one for 2013 and one for 2014.

Thank you for your time and attention during this benefits presentation. We hope you found the information valuable. If you have any questions, please feel free to contact your HR manager, local HR administrator or the Employee Benefits Service Center for assistance or you can visit the 360 site, Human Resources, Benefits, and click on the Open Enrollment icon.



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