EXHIBIT 1

THE COUNTY OF VENTURA

HEALTH CARE
FLEXIBLE SPENDING ACCOUNT PLAN

(Effective as of September 23, 1984)

(As Amended September 14, 2010)

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Article I. Establishment of the Plan

1.1 Establishment of the Plan. THE COUNTY OF VENTURA, a political subdivision of the State of California (the "County") hereby establishes a health care expense program, to be known as "THE COUNTY OF VENTURA HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN" (the "Plan"). This Plan is intended to qualify as a plan described in Section 105 of the Internal Revenue Code, as amended. The Plan is established effective as of September 23, 1984, in order to provide release of funds to eligible Employees who incur health care expenses not covered by their medical, dental or vision plans.

1.2 Applicability of Plan. The provisions of this Plan are applicable only to the Employees of the County in current employment who are Members of the County of Ventura Flexible Benefits Program (the "Flexible Benefits Program") and who are eligible to select the health care flexible spending account benefit thereunder. At termination of employment a Member may continue contributions for the period allowed in accordance with the continuation of health benefits provided by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

1.3 Provision for Payment of Benefits. Payment of the cost of benefits which are provided under this Plan comes from three sources: (1) the Member through flexible credits generated by elective pay reduction, as provided under sections 4.2 and 4.3 of the Flexible Benefits Program, (2) the County through allocation of flexible credits contributed under section 4.1(a) of the Flexible Benefits Program, and (3) the Member through contributions made in accordance with COBRA continuation of benefits, if elected, or during an unpaid leave of absence.

Article II. Definitions and Construction

2.1 Definitions. Terms used in capitalized form in this Plan shall have the meaning set forth in the Flexible Benefits Program Plan Document.

2.2 Gender and Number. Except when otherwise indicated by the context, any masculine terminology shall also include the feminine and the definition of any term in the singular shall also include the plural.

2.3 Illegality of Particular Provision. The illegality of any particular provision of this Plan shall not affect the other provisions, but the Plan shall be construed in all respects as if such invalid provision were omitted.

2.4 Applicable Laws: This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). As set forth in section 5.4, in no event shall the County guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of California.

Article III. Eligibility and Participation

3.1 Date of Participation. An Employee who is a Member of the Flexible Benefits Program, who is eligible under the Plan and the adoption agreement of his Participating Group for the health care flexible spending account benefit described in sections 5.1(c) and 5.4 thereof with respect to a Period of Coverage, and who selects that benefit shall be eligible for release of funds for covered expenses incurred during that Period of Coverage plus a grace period of 2 and ½ months or up to March 15th following the end of the plan year.

3.2 Election of Benefits Coverage. The election of benefits under this Plan shall be made in conformance with section 4.4 of the Flexible Benefits Program and shall remain in effect until the end of the Plan Year unless a change is made as authorized by section 4.4 of the Flexible Benefits Program.

3.3 Effect of Change in Election on Maximum Health Benefits. Any change in election affecting annual Plan contributions to the Member's health care flexible spending account pursuant to section 4.4 of the Flexible Benefits Program (or the automatic change of election described in section 3.4 of this Plan) will also change the maximum health care flexible spending account benefits for the Period of Coverage remaining in the Plan Year. The maximum health care flexible spending account benefit for the Period of Coverage following an election change shall be calculated by adding (or subtracting if a negative balance) the balance remaining in the Member's health care flexible spending account as of the end of the portion of the Plan Year immediately preceding the change in election, to the total plan contributions scheduled to be made by the Member during the remainder of such Plan Year.

3.4 Automatic Change of Election During Unpaid Leave of Absence. Any member on an unpaid leave of absence will be deemed to have elected to change his or her employee contribution to the health care flexible spending account to zero in accordance with section 4.4 of the Flexible Benefits Program for the duration of the unpaid leave of absence; and will be deemed to have changed his or her contribution to the amount in effect just prior to the unpaid leave of absence upon his or her return to paid status. The maximum health care flexible spending account benefit for the remaining Period of Coverage shall be adjusted as described in section 3.3 of this Plan. The Member's Period of Coverage shall not be affected by the aforesaid contribution changes, and covered expenses incurred during the entire Period of Coverage shall be eligible for release of funds. Any member wishing to make a change of election different than that described in this section, shall notify the Plan Administrator of his or her election change no later than

seven days after the beginning of the Member's unpaid leave of absence. Failure to notify the Plan Administrator within the period prescribed shall be considered to be acceptance of the automatic election changes described herein.

3.5 Revocation of Election on Termination of Service: The election of any Member who terminates or is discharged from employment with the County will be automatically terminated on the effective date of such termination or discharge. No such Member shall be entitled to receive payments for claims incurred after the period covered by contributions made prior to the termination or discharge date**.** Any plan contributions made for the portion of the Plan Year extending beyond such coverage period will be refunded to the Member. Provided, however, that any such Member may continue to make contributions to and participate in the Plan if he or she is otherwise eligible to participate in the Plan and notifies the Plan Administrator in writing of such desire, in accordance with section 1.2 of this Plan.

Article IV. Covered Health Care Expenses

4.1 Amount. A Member who has selected the health care flexible spending account benefit under sections 5.1(c) and 5.4 of the Flexible Benefits Program and/or who has reduced his pay as provided in sections 4.2 and 4.3 of the Flexible Benefits Program may submit claims for Covered Expenses, as described in this Article IV, to the office designated by the County. The County shall release funds to the Member directly for eligible expenses up to the maximum amount which the member has designated to be credited to his health care flexible spending account for the Plan Year, less the dollar amount of claims previously paid during the Plan Year, subject to the limitation that for any Plan Year, the sum of a Member's pay reductions under sections 4.2 and 4.3 of the Flexible Benefits Program, Employer Contributions allocated to the Member's health care flexible spending account under section 5.1(c) of the Flexible Benefits Program and other Member Contributions made after separation from service cannot be less than $240 per year and cannot exceed $5,000.00 effective January 1, 2011. This maximum contribution amount will decrease to $2,500.00 per year effective January 1, 2013, and will be adjusted for inflation annually thereafter.

4.2 Claim Procedure. The member shall file a claim for the payment of covered health care expenses on the County's Health Care Flexible Spending Account claim form (or other designated form). With the completed claim form, the member shall submit an itemized bill, Explanation of Benefits (EOB) or itemized receipt or a written statement provided by an independent third party (e.g., a doctor, dentist, pharmacist, etc. as appropriate) indicating the patient name, specific health care expense(s) incurred, the expense amount, and the date(s) the expenses(s) were incurred. For expenses relating to personal items (such as a wig, sunglasses or similar items), you must submit a written statement by your health care provider or other independent third party (e.g., a doctor, dentist, pharmacist, etc.) substantiating that the expense was medically necessary. The member shall also sign a statement confirming that the expense has not been reimbursed, will not be reimbursed, and is not reimbursable under any other health plan coverage.

4.3 Covered Expenses. Health care flexible spending account claims may be submitted only for employee, spouse or eligible dependent (as defined in section 4.4 of this Plan) health care expenses.

Any health care expenses allowed under IRS Code section 105(b) shall be covered under this Plan to the extent that they are not eligible for reimbursement under any other medical, dental or vision plans covering the Member or Eligible Dependents. Examples of such expenses are:

-Medical and dental plan deductibles and co-payments

-Mental health services and substance abuse treatment

-Routine physical examinations

-Vision care

-Chiropractic services

-Orthodontia

-Other dental services

-Hearing aids

-Medical equipment (rental or purchase)

-Other medical expenses, including transportation expenses

4.4 Eligible Dependent. An Eligible Dependent means any person as defined in section 152 of the Internal Revenue Code as amended. Any child to whom section 152(e) applies shall be treated as a dependent of both parents for purposes of this plan.

4.5 Unused Credits Allocated to Flexible Spending Account. Claims for health care expenses incurred during a Period of Coverage and grace period may be submitted at any time during the Period of Coverage and grace period but no later than April 15 (or the next following business day if April 15 falls on a weekend or holiday) of the following Plan Year. The County may waive or extend this period for submitting claims for an Employee if, in the opinion of the Plan Administrator, circumstances warrant such action.

Claims for expenses incurred during the grace period shall be applied to any flexible credits balance remaining from the prior Period of Coverage. If no flexible credits remain from the prior Period of Coverage, the claims for health care expenses incurred during the grace period shall apply to the current Period of Coverage. Any flexible credits remaining in any flexible spending account after all claims for expenses incurred during a Period of Coverage and grace period have been paid shall be forfeited.

4.6 Qualified Reservist Distributions Under the conditions set forth in this section 4.6, effective June 18, 2008, a Member who is a member of a “reserve component” (as such term is defined in section 101 of title 37, United States Code) may qualify for a

"qualified reservist distribution" ("QRD") of all or a portion of the Member's health care flexible spending account balance. Generally, a QRD is a distribution to an individual of all or a portion of the balance in the individual's health care flexible spending account if: (1) the individual is a member of a reserve component ordered or called to active duty for a period of at least 180 days, or for an indefinite period, and (2) the request for distribution is made during the period beginning with the order or call to duty and ending on the last day of the Plan Year (plus the 2 and ½ months grace period) that includes the date of the order or call to duty. A Member ordered or called to active duty prior to June 18, 2008, is eligible for a QRD if his or her period of active duty continues after June 18, 2008, and satisfies the minimum 180-day duration requirement.

To apply for a QRD, a Member must provide a copy of the order or call to duty to the office designated by the County, along with a written request specifying the amount of the requested distribution. They County may provide a standard form for making QRD requests. The maximum amount available for a QRD shall be the amount contributed to the Member's health care flexible spending account as of the date of the QRD request, minus the amount of any health care flexible spending account reimbursements paid in the applicable Plan Year as of the date of the QRD request. A QRD may not be made with respect to (1) amounts forfeited prior to June 18, 2008, or (2) attributable to a Plan year ending before June 18, 2008. A Member may make one QRD request for each instance in which the Member is ordered or called to active duty. A QRD request will not affect a Member's ability to make claims for health care flexible spending account reimbursements.

Article V. Administration

5.1 Administration. The County shall administer the Plan and shall have the authority to exercise the powers and discretion conferred by the Plan and shall have such other powers and authority necessary or proper for the administration of the Plan as shall be determined from time to time by the County.

The Board may adopt such rules and regulations for the administration of the Plan as it shall consider advisable and shall have full power and authority to enforce, construe, interpret, and administer the Plan. All interpretations under the Plan and all determinations of fact made in good faith by the County shall be binding on the Members, their dependents, and all other interested persons.

The Board may delegate to any agent, attorney, accountant, or other person selected by it, any power or duty vested in, imposed upon, or granted to it by the Plan.

5.2 Nondiscrimination. The contributions or benefits provided under this Plan shall not discriminate in favor of employees who are officers or highly compensated, or their dependents.

5.3 No Guarantee of Tax Consequences. Neither the County nor the Plan Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Member under the Plan will be excludable from the Member's gross income for

Federal, state or local tax purposes, or that any other Federal, state or local tax treatment will apply to or be available to any Member. It shall be the obligation of each Member to determine whether each payment under the Plan is excludable from the Member's gross income for Federal, state and local income tax purposes, and to notify the County if the Member has reason to believe that any such payment is not so excludable.

IN WITNESS WHEREOF, THE COUNTY OF VENTURA has caused this instrument to be executed, effective as of September 23, 1984, and as amended September 14, 2010.

ADOPTED:

The Board of Supervisors of the
COUNTY OF VENTURA

By _____

ATTEST:

MARTY ROBINSON,
Clerk of the Board of Supervisors,
County of Ventura
State of California

By _____
Deputy Clerk of the Board