ADVANCE HEALTH CARE DIRECTIVE

By this document I, CEZANNA C. PHILIPPON MALTER, of 2445 Lakewood Dr., Prescott, AZ 86301, intend to create an advance health care directive. This advance directive shall not be affected by my subsequent incapacity. All references herein to "my agent" refer to the agent acting at the pertinent time.

ARTICLE ONE. POWER OF ATTORNEY FOR HEALTH CARE

1.1 Designation of Health Care Agent

I do hereby designate and appoint MICHAEL R. MALTER of 2445 Lakewood Dr., Prescott, AZ 86301, (415) 462-2941, as my agent (referred to in this document as my "agent") to make healthcare decisions for me as authorized in this document.

1.2 Alternate Agent

If MICHAEL R. MALTER is not reasonably available, able, or willing, or becomes ineligible to act as my agent to make healthcare decisions for me, or if I revoke the appointment or authority to act as my agent to make healthcare decisions for me, then I designate the following persons to serve as my agent in the order listed below:

1. SHELLEY OCAÑA, professional fiduciary of Santa Rosa, California, (707) 528-1364;

2. JACQUELYNNE OCAÑA, professional fiduciary of Santa Rosa, California, (707) 528-1364; and

3. CATHERINE OCAÑA, professional fiduciary of Santa Rosa, California, (707) 528-1364.

CCM

1.3 General Statement of Authority Granted

Subject to any limitations in this document, I hereby grant to my agent full power and authority (a) to make health care decisions for me to the same extent that I could make those decisions for myself if I had the capacity to do so, including, without limitation, decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, including cardiopulmonary resuscitation; and (b) to make personal care decisions for me to the same extent that I could make those decisions for myself if I had the capacity to do so, including, without limitation, determining where I will live, providing me meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment for me.

1.4 Period During Which Agent's Authority Is Effective

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions. My agent's authority ceases to be effective when my primary physician determines that I am again able to make my own health care decisions.

1.5 Agent's Obligation

My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Article Two of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

CCM

1.6 Anatomical Gifts

My agent shall have the power and authority to make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act as provided in Article Four.

1.7 Disposition of Remains

I wish to be cremated. My agent shall have the power and authority to direct the disposition of my cremated remains according to their discretion.

1.8 Arrangements for Funeral or Memorial Service

My agent shall have the power and authority to arrange for my funeral or other memorial service.

1.9 Authorization of Autopsy

My agent shall have the power and authority to authorize an autopsy.

1.10 Nomination of Conservator of Person

If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person: MICHAEL R. MALTER of 2445 Lakewood Dr., Prescott, Az 86301.

ARTICLE TWO. INSTRUCTIONS FOR HEALTH CARE

2.1 End-of-Life Decisions

I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery and my death is likely to occur

CCM

within several months, or if I require life support as the result of an irreversible condition, even if that life support might prolong my life for a sustained period. Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances in which the burdens of treatment outweigh the expected benefits. By an "irreversible coma," I mean a coma from which the treating physicians have reasonably concluded I will never regain consciousness. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

2.2 Relief from Pain and Palliative Care

I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death. I wish to receive any other forms of palliative care that may ease my suffering.

ARTICLE THREE. INSTRUCTIONS FOR PERSONAL CARE

3.1 Independent Living

I wish to live in my primary residence for as long as that is reasonably possible without endangering my physical or mental health or safety and to receive whatever assistance from household employees or personal care givers may be necessary to permit me to do so. I wish to return home as soon as reasonably possible after any hospitalization or transfer to convalescent care. If my agent determines that I am no longer able to live in my home, I wish that my agent

CCM

considers alternatives to convalescent care which will permit me as much privacy and autonomy as possible, including such options as placing me in an assisted living facility or board and care facility.

3.2 Social Interaction

I wish to be encouraged to maintain my social relationships and to engage in social interaction even if I am no longer able to recognize my family and friends or to fully participate in social activities.

ARTICLE FOUR. DONATION OF ORGANS AT DEATH

4.1 Organ Donation

Upon my death, my agent may donate any needed organs, tissues, or parts.

ARTICLE FIVE. PRIMARY PHYSICIAN

5.1 Agent's Authority to Select Primary Physician

My agent shall at all times have the power and authority to select a primary physician for me as my agent deems appropriate; provided, however, that my agent shall at all times select as such primary physician the physician whom I would have chosen as my primary physician if I had been able to make such a choice (and my regular and continuous use of a particular physician shall be deemed sufficient evidence of what choice I would have made in this regard). My purpose in including this section 5.1 is to indicate my understanding that I may change primary physicians from time to time and, to the extent such changes are known to my agent, I would like my agent to use such knowledge to override any contradictory provisions contained in this directive.

CCM

ARTICLE SIX. MISCELLANEOUS MATTERS

6.1 HIPAA and CMIA Health Information Release

I intend my agent, as my "personal representative" as that term is used in the Health Insurance Portability and Accountability Act, 42 U.S.C. § 1320d, 45 C.F.R. Parts 160 and 164, to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. The authority of my agent with respect to the use and disclosure of such information and records shall control my agent's dealings with any physician or other health care provider who is providing health care services to me at any time when my agent shall seek access to such information and/or records. Subject to any limitations in this document, my agent has the power and authority to do the following:

(a) Request, review, and receive from any physician or any other "covered entity" as defined under HIPAA, any information, verbal or written, regarding my physical or mental health, including, but not limited to, any medical and hospital records, including all of my individually identifiable health information and medical records regarding any past, present or future physical or mental health conditions, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse;

(b) Execute on my behalf any releases or other documents that may be required in order to obtain such information, including, but not limited to, a Valid Authorization under the California Confidentiality of Medical Information Act and the Health Insurance Portability and Accountability Act;

(c) Consent to the disclosure of such requested information.

CCM

6.2 Signing Documents, Waivers, and Releases

When necessary to implement the health care decisions, my agent is authorized to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice," and

(b) Any necessary waiver or release from liability required by a hospital or physician.

6.3 Prior Designations Revoked

I revoke any prior durable power of attorney for health care or advance health care directive.

6.4 Advice of Lawyer Obtained

My lawyer has advised me concerning my rights in connection with this advance directive and the applicable law and the consequences of signing or not signing this advance directive.

6.5 Use of Photocopies Permitted

Persons dealing with my agent may rely fully on a photocopy of this instrument as though the photocopy was an original.

DATE AND SIGNATURE OF PRINCIPAL

Executed on March 9, 2018, at Prescott, Arizona.

Cezanna C. Philippon Malter

CEZANNA C. PHILIPPON MALTER

CCM

I affirm that the foregoing Advanced Healthcare Directive for Cezanna C. Philippon Malter was signed or acknowledged in my presence, and that the person signing this document (the principal) appears to be of sound mind and under no duress. I am at least 18 years of age. I am not designated to make medical decisions on the principal's behalf. I am not directly involved with the provision of heath care to the principal. I am not entitled to any portion of the principal's estate upon his other death, whether under any will or by operation of law. I am not related to the principal by blood, marriage or adoption.

Witness

State of Arizona)
) ss.
County of Yavapai)

Subscribed, sworn to, and acknowledged before me by Cezanna C. Philippon Malter and subscribed and sworn to before me by Robert A. Miller, this 9 day of March 2018.

My commission expires/seal:

Notary Public

THERESA MURRAY
NOTARY PUBLIC, ARIZONA
YAVAPAI COUNTY
My Commission Expires
August 9, 2021

CCM