HADASSAH UNIVERSITY MEDICAL CENTER
Founded by Hadassah, the Women's Zionist Organization of America

Patient First Name: ALEKSANDR
Patient Last Name: NEPYTAEV
Record Number: Z- 5318485
Passport Number/Nationality: 857066

Date of Issue: 16.06.2024
Print Date: 24.06.2024
Reference: 30811450

RE: Estimated Cost of Bone Marrow Transplantation

We are looking forward to welcoming you to our medical center.
In response to your request, please find below the estimated pricing for the bone marrow procedure.
This price estimate is provided based on the medical documents made available by the patient.
This price offer is not an approval for arrival to Hadassah. Arrival approval will be provided only after physician's approval.

A. Procedure: Matched Unrelated Donor Stem Cell Transplantation

B. Details*

Service code	Service name	Doctor's Name	Quantity	Cost in Euro
996227	Private consultation	Dr. Zaidman	1	564
149004	Unrelated donor search/charges for family member donor*		1	25,064
520014	Molecular HLA confirmatory typing for patient him/herself		1	3,111
996227	Private consultation	Dr. Zaidman	6	3,384
996227	Private consultation	General Doctor	3	1,692
996228	Port-a-Cath/central line insertion	General Doctor	1	2,034
227022	Port-a-Cath		1	2,368
996226	Echo-cardiology	Dr. Golender	1	611
293004	Pediatric echo-cardiology		1	239
149005	Transplantation of matched unrelated donor (3 months)		1	145,002
996225	Stem cell transplantation	Dr. Zaidman	1	9,615
149006	Additional three months post- transplant treatment hospitalization package		1	39,118
999343	Lodging/Accommodations** (up to 7 months for patient and accompanying person)		7	7,198
Total charges				**240,000**

In cases in which the transplantation shall require cord blood or an implant from a specific bone marrow donor registry, there may be additional charges for the transplantation package. Additional cost for cord blood implant can be up to $80,000.

*Quoted prices are valid for 90 days.
** Accommodations beyond 7 months will be charged at 1028 Euro per month.

The cost of the transplant includes:

1. Preparation of the transplant (for both the recipient and the donor).
2. Hospitalization, (including chemotherapy, radiation, immuno-conditioning with anti-thymocytic antibodies, other medications, hyperaliamentation and the transplant itself including procurement costs).
3. Blood products including single donor apheresis for platelets and red blood cells (including filtration and irradiation).
4. Transplant fee includes initial dental check-up.
5. Pre- transplant treatment for a maximum of three weeks prior to the transplantation.
6. Post-transplant treatment for a maximum of six months after the transplant and preparatory period, up to three weeks before the transplant (which includes medications and if needed the cost of other hospitalizations).

The cost of the transplant excludes:

1. Transplant fee does not include dental treatment.
2. Transplant fee does not include **WHOLE EXOME SEQUENCING**.
3. Molecular HLA conformity typing for family members: If needed will be charged at **Euro 3,111** for each family member.
4. This proposal does not include a pre-transplant treatment required for induction of remission or tumor debulking prior to transplantation.

Please note:

- Additional hospitalization days will be charged at the rate of **Euro 2,000** per day.
- In the event that additional three month hospitalization package is required (beyond 6 months), it will be charged at the rate of **Euro 39,118**.
- Any additional surgery, other than the transplant, will be charged per service.
- This quote may be changed based on the treatment instructions of the treating physicians.
- Additional costs may be incurred for additional testing and/or procedures that may arise throughout the anticipated medical care. They will be charged based on Hadassah's rate at the time of treatment.

C. Payment:

Full payment of **Euro 240,000** is required prior to the initial assessment.

For your convenience, a bank transfer can be made to the Hadassah Medical Organization account. (Please keep in mind that it takes approximately 3 working days to credit the hospital's account).

Payment should be made payable to:

Hadassah Medical organization- swift code POALILITXXX,

Bank Hapoalim, #436, Harokmim St. 26, Holon, Israel.

IBAN CODE: IL410124360000000025000

Account Number 25000

Please send a copy of your bank transfer (swift) to: Laurence@hadassah.org.il

Please do not hesitate to contact us if you require any additional information or assistance via mail to bid@hadassah.org.il or by phone: 972-2 6779111

Hadassah University Medical Center
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