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

Patient First Name: MARIIA
Patient Last Name: SHABALINA
Record Number: Z- 3729832
Passport Number/Nationality: 750838893

Date of Issue: 23.06.2022
Print Date: 26.06.2022
Reference: 30329420

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.

A. Procedure: Matched Unrelated Donor Stem Cell Transplantation

B. Details*

Service code	Service name	Doctor's Name	Quantity	Cost in USD
999777	Private consultation	Dr. Zaidman	1	575
149072	Unrelated donor search*		1	24,357
520021 520009 520005	Molecular HLA confirmatory typing for patient him/herself		1	2,760
999777	Private consultation	Dr. Zaidman	6	3,450
999777	Private consultation	General Doctor	3	1,725
997852	Port-a-Cath/central line insertion	General Doctor	1	1,977
227487	Port-a-Cath		1	2,197
997457	Echo-cardiology	Dr. Golender	1	593
293039	Pediatric echo-cardiology		1	221
149559	Transplantation of matched unrelated donor (3 months)		1	132,969
996624	Stem cell transplantation	Dr. Zaidman	1	9,344
149574	Additional three months post- transplant treatment hospitalization package		1	32,482
999343	Lodging/Accommodations** (up to 7 months for patient and accompanying person)		7	7,350
Total charges				**220,000**

The provision of this price offer document does not guarantee the performance of the BMT.

BMT, will be performed only if the patient is in a remission state.

*Quoted prices are valid for 90 days.
** Accommodations beyond 7 months will be charged at $1,050 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. 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. In rare 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 $48,000.**
4. Molecular HLA conformity typing for family members: If needed will be charged at **$ 2,760** for each family member.
5. 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 **$2,000** per day.
- In the event that additional three month hospitalization package is required (beyond 6 months), it will be charged at the rate of **$ 32,482**
- 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.

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C. Payment:

Full payment of $ 220,000 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
INTERNATIONAL PATIENT DEPARTMENT

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