Memorandum of Understanding
Between
State Bank of India
And
Local 2110/ UAW

1. The contract dated November 1, 2001 shall be amended in accordance with this memorandum of understanding (MOU) . All provisions not changed by this MOU shall continue in effect.

2. Employees shall receive an increase of $25 per week effective July 1, 2004.

3. Current health and dental insurance shall be changed as follows:

i) In network benefits provided under the Aetna plan shall continue without change.
ii) Out of network benefits under the Aetna plan will be changed in accordance with the plan described under attachment 'A'.
iii) Dental benefits shall be provided by Guardian in accordance with the plan described in attachment 'B'.

4. The Bank will pay up to $ 794.15 per month for medical and dental insurance premium.

5. The Bank will offer a voluntary retirement program (VRP) subject to approval by the Head Office. The VRP shall have the following features:

i) Employees to be eligible shall have either (a) at least 15 years of service or (b) age plus years of service equal to at least 70 years.
ii) Employees shall receive (a) three weeks of pay per completed year of service and (b) continuation of medical and dental insurance for a period of 12 months. Employees may elect a lump sum payment in lieu of continuation of insurance, equal to the amount of the premium for 12 months.
iii) Employees will have 45 days to elect to participate.
iv) Participants will be limited to the most senior 15 (fifteen) employees who apply for the plan.
v) All other provisions to be the same as the VRP offered in 2002, including requirement that employees sign a release.

6. Contract to be effective from July 1, 2004 through June 30, 2005.

7. All other proposals by both parties are withdrawn.

Dated at New York, New York, October 19, 2004

STATE BANK OF INDIA, NEW YORK **Local 2110/ UAW**

Subject to membership ratification

By..... By.....

EXHIBIT A
10-19-04

FRANK CRYSTAL & COMPANY

State Bank Of India

Medical Plan Design and Cost Comparison - Negotiated Renewal vs. Alternative Aetna Plan

NEW MEDICAL PLAN

	Enrollment			Aetna (Current)		Aetna (Negotiated Ren.)		One Offering			
				Point Of Service		Point Of Service		Aetna Gated POS - New York		Aetna Gated POS - Chicago, IL	
	NY	Other	All	In	Out	In	Out	In	Out	In	Out
Calendar Year Deductible				None	$500/$1,500	None	$500/$1,500	None	**$5,000/$15,000**	None	**$1,000/$3,000**
Coinsurance				N/A	80%	N/A	80%	N/A	**50%**	N/A	**50%**
Coinsurance Limit				N/A	$2,000/$4,000	N/A	$2,000/$4,000	N/A	**$30,000/$90,000**	N/A	**$10,000/$30,000**
Annual Maximum Benefit				Unlimited	$1,000,000	Unlimited	$1,000,000	Unlimited	**$50,000**	Unlimited	**$500,000**
PCP Copay				$10	Ded. & Coins.	$10	Ded. & Coins.	$10	Ded. & Coins.	$10	Ded. & Coins.
Specialist Copay				$10	Ded. & Coins.	$10	Ded. & Coins.	$10	Ded. & Coins.	$10	Ded. & Coins.
Hospital				100%	Ded. & Coins.	100%	Ded. & Coins.	100%	Ded. & Coins.	100%	Ded. & Coins.
Emergency Room (waived if admitted)				$25	$25	$25	$25	$25	$25	$25	$25
Prescription Drugs				$5/$10/$25		$5/$10/$25		$5/$10/$25		$5/$10/$25	
Rates											
Single	20	4	24	$290.20		$340.11		$309.84		$309.84	
Family	100	26	126	$674.80		$790.87		$720.48		$720.48	
Monthly Premium				**$91,990**		**$107,812**		**$98,217**			
Annual Premium				**$1,103,875**		**$1,293,742**		**$1,178,600**			
$ Change from Aetna Current				N/A		**$189,867**		**$74,724**			
% Change from Aetna Current				N/A		**17.20%**		**6.77%**			
$ Change from Aetna Renewal				N/A		N/A		**-$115,142**			
% Change from Aetna Renewal				N/A		N/A		**-8.90%**			

This proposal is a general description of coverage(s) provided. For a detailed description of policy terms and conditions, please refer to the policy itself.

If a conflict exists between this proposal and the policy, the policy will be controlling.

Proposed rates are estimated and based on census provided. Final rates are based on Effective Date, Plan Design & Actual Enrollment.

*** Due to filing restrictions, plan #2 would be provided in Illinois, Maryland, and Virgina. Plan #1 to all others, but with a $500,000 OON annual max. in Connecticut.**

EXHIBIT B
10-19-04

GUARDIAN®

Schedule of Benefits
DentalGuard

Schedule A Description

Dual Option with 5NYM

143 Employees

DentalGuard Enhanced Network Access -- Plan Type UY

DentalGuard Preferred in (New York, NY)

In-Network Schedule Features

- There is no deductible.
- We pay 100% of covered charges for Preventive services, 80% of covered charges for Basic services, and 50% of covered charges for Major services to a maximum of $1,500 per benefit year, per covered person.
- If you go to a DentalGuard Preferred Network provider, the benefits described above will be paid based on a reduced fee schedule (this will mean less out-of-pocket). The network provider cannot balance bill for charges in excess of the fee schedule and you get more services with your yearly maximum. If you go to a non-contracted dentist, the benefits will be based on usual, customary and reasonable rates for a given area.
- Orthodontia is not covered.

Out-of-Network Schedule Features

- The individual deductible amount is $50 per calendar year.
- There are three (3) individual deductibles per family. If three family members pay the cash deductible in a calendar year, the deductible for all other insured family members will be waived for the rest of year. A two-deductible-per-family limit is also available.
- The deductible is waived for Preventive services.
- We pay 100% of covered charges for Preventive services, 80% of covered charges after the deductible for Basic services, and 50% of covered charges after the deductible for Major services to a maximum of $1,500 per benefit year, per covered person.
- Orthodontia is not covered.

continued

Schedule A Description (continued)

Other Schedule Features

- Children are covered up to age 20 or to age 26 if full-time student.
- No deferred services have been elected.

continued

Schedule Exclusions

- Except as explained in Replacement Plan, we do not pay for a prosthetic device replacing teeth lost before a covered person became insured for this plan. But we will pay for a device to replace those teeth if it also replaces teeth lost or extracted while the covered person is insured by this plan.
- We do not pay for replacing an appliance or prosthetic device with a like appliance or any appliance or prosthetic device, unless: (a) it is at least ten years old and can't be made usable, or (b) it is damaged while in the covered person's mouth in an injury suffered while insured and can't be fixed.
- We do not pay for general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and 'Other Oral Surgical Procedures' as defined by the contract; local anesthetic if billed as a separate procedure.

Schedule Assumptions

- Contributory for Employees and Dependents.
- 75% of all eligible employees or 90% of all employees that are not covered elsewhere must be enrolled.
- 75% of all eligible dependents that are not covered elsewhere must be enrolled.
- If employee participation is less than 75%, or less than 10 employees enroll, contact The Guardian Group Sales Office for possible exceptions.
- Usual, customary and reasonable (UCR) charges are limited to the 90th percentile.
- The proposed plan meets all legal conditions and The Guardian's underwriting requirements.

continued

Estimated Monthly Cost*

DentalGuard	Number	Rate	Premium
Dental			
Employee Only	16	$28.66	$458.56
Family	127	73.67	9,356.09
		Monthly Premium	$9,814.65
		Annual Premium	$117,775.80

- Rates are calculated on a Plan level.
- This quote assumes that the group is currently covered by a group dental plan. If the group is not currently covered by a group dental plan, an increase of 10% will be applied to these rates.
- Dental insurance plans can be sold stand-alone.

* Rates and premium are estimates based on the employee data submitted. Final rates and premiums are based on the plan of insurance and the employee and dependent data taken from the enrollment cards.

Proposal Conditions

The cost is based on census data submitted for Proposal purposes. The Final Rates may vary if the actual enrollment differs from the census data submitted for quotation. This proposal is valid for 90 days from the proposal date.

This proposal is hedged subject to satisfactory financial evaluation.

This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect or injury. Deductibles may apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments, any treatment to the extent benefits are payable by any other payor or for which not charge is made, prosthetic devices, unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic and prosthodontic services. The services, exclusions, and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. (GP-1-DG2000 et al)

Schedule of Benefits
Managed DentalGuard Prepaid Plan

Code	Service Description	PATIENT CHARGES 05NYM Ortho 9	AVERAGE FEE*
N/A	Office visit charge	$5.00	N/A
Diagnostic and Preventive Services			
0120	Oral evaluation	No Charge	$40.00
1110	Teeth cleaning (prophylaxis)	No Charge	$80.00
0274	Bitewing x-rays	No Charge	$50.00
Fillings			
2140	Amalgam, one surface	$13.00	$120.00
2150	Amalgam, two surface	$16.00	$150.00
Crown and Bridge			
2752	Porcelain with noble metal crown	$275.00	$875.00
2792	Full cast noble metal crown	$275.00	$925.00
Endodontics			
3320	Root canal therapy, bicuspid	$110.00	$745.00
3330	Root canal therapy, molar	$140.00	$875.00
Periodontics			
4210	Gingivectomy, per quadrant	$75.00	$725.00
4260	Osseous surgery, per quadrant	$140.00	$895.00
4341	Periodontal scaling and root planing	$30.00	$225.00
Dentures			
5110	Complete denture, upper	$330.00	$1,600.00
5211	Partial upper denture, resin base	$275.00	$1,250.00
5630	Repair or replace denture clasp	$50.00	$175.00
Oral Surgery			
7110	Extract single tooth	$17.00	$150.00
7241	Extract impacted tooth, completely bony	$75.00	$450.00
Orthodontia * *			
8601	Orthodontia evaluation	$100.00	* *
8080	Orthodontia treatment, child, up to 24 months	$1,425.00	$4,500.00
8090	Orthodontia treatment, adult, up to 24 months	$2,425.00	$4,500.00
8680	Orthodontic retention	$425.00	* *

* The average fees shown above are typical covered charge amounts for the listed services in the New York area, as defined by the Health Insurance Association of America's Prevailing HealthCare Charges System.

* * Charges for initial evaluation and orthodontic retention are generally included in a comprehensive fee.

continued

GUARDIAN®

The Managed DentalGuard plan offers you:

- Unlimited maximum benefits
- No deductibles
- No claim form required
- Participating offices always have current eligibility information, regardless of office hours
- Specialist services available by referral
- Members always know out-of-pocket costs
- Out-of-area emergency benefit of up to $50 per incident, per member
- No exclusions for pre-existing conditions
- No monthly administrative fee
- No participation requirements
- No employer contribution required

Benefits under the Managed DentalGuard plan are limited to what is listed in the contract. Except for limited emergency services, benefits will be provided only for services provided by the dentist selected as primary care dentist by the plan member. The member is required to pay the primary care dentist a patient charge for most covered services. No benefits will be provided for treatment by a specialist unless the patient is referred by his primary care dentist and the referral is approved by Guardian.

Proposal Conditions

The cost is based on data submitted for proposal purposes. The final rates may vary if the actual enrollment differs from the data submitted.

continued

GUARDIAN®

Managed DentalGuard Prepaid Plan
Estimated Monthly Cost

		05NYM Ortho 9	
	Number	Rate	Premium
Employee Only	16	$28.66	$458.56
Family	127	$73.67	9,356.09
Total Monthly Premium			$9,814.65
Total Annual Premium			$117,775.80

FRANK CRYSTAL & COMPANY

State Bank Of India

Dental Plan Design and Cost Comparison - Renewal vs. Guardian

NEW DENTAL PLAN

Benefit Summary		Aetna (Current) Freedom Of Choice			Aetna (Renewal 11/1/04) Freedom Of Choice			Guardian Dental Care		
		DMO	Passive PPO		DMO	Passive PPO		DMO	PPO	
		Network	In-Network	Out-of-Network	Network	In-Network	Out-of-Network	Network	In-Network	Out-of-Network
Deductible		None	$50/$150		None	$50/$150		None	None	$50/$150
Calendar Year Maximum		None	$1,500		None	$1,500		None	$1,500	
Orthodontia Maximum		N/A	N/A		N/A	N/A		Schedule	N/A	
Preventive & Diagnostic										
Oral Exams		100%	80%	80%	100%	80%	80%	Schedule	80%	80%
X-rays		100%	80%	80%	100%	80%	80%	Schedule	80%	80%
Flouride Treatments		100%	80%	80%	100%	80%	80%	Schedule	80%	80%
Basic										
Oral Surgery		100%	80%	80%	100%	80%	80%	Schedule	80%	80%
Extractions		100%	80%	80%	100%	80%	80%	Schedule	80%	80%
Fillings		100%	80%	80%	100%	80%	80%	Schedule	80%	80%
Endodontic		100%	80%	80%	100%	80%	80%	Schedule	80%	80%
Major										
Denture Replacement		60%	50%	50%	60%	50%	50%	Schedule	50%	50%
Installation of Dentures		60%	50%	50%	60%	50%	50%	Schedule	50%	50%
Gold Fillings & Crowns		60%	50%	50%	60%	50%	50%	Schedule	50%	50%
Orthodontia		N/A	N/A	N/A	N/A	N/A	N/A	Schedule	N/A	N/A
Monthly Rates										
Employee	23		$44.98			$47.00			$28.66	
Family	129		$96.82			$101.18			$73.67	
TOTAL	152									
Total Monthly Premium			$13,524			$14,133			$10,163	
Total Annual Premium			$162,292			$169,599			$121,951	
$ Change from Renewal			N/A			$0				
% Change from Renewal			N/A			N/A				
$ Change from Current			N/A			$7,307				
% Change from Current			N/A			4.50%				
Average annual cost per employee			$1,069			$1,116				

This proposal is a general description of coverage(s) provided. For a detailed description of policy terms and conditions, please refer to the policy itself.
If a conflict exists between this proposal and the policy, the policy will be controlling.
Proposed rates are estimated and based on census provided. Final rates are based on Effective Date, Plan Design & Actual Enrollment.