**Protective effectiveness of SARS-CoV-2 infection risk between hybrid and vaccine-induced immunity against the omicron variant**

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**Abstract**

**Background.** Our study examined the protective effectiveness of COVID-19 infection across age groups between hybrid and vaccine-induced in the general population based on community-based nationwide surveillance.

**Methods:** We defined the hybrid and vaccine group based on information from serology (S and N status) and self-reporting on previous vaccination and testing as accurately as possible, avoiding many sources of bias that would lead to differential misclassification of people as infected. We illustrated the S antibody level and associated protective efficacy against breakthrough infection over time by age group and immunity status. Based on the identified risk factors by the immunity groups, we quantified the probability of free from infection risk by age group so it can guide the specific vaccine prioritization and interval for age groups.

**Results:** We showed that S ab waning and risk infection trends are highly correlated; hybrid group resulted in higher and longer-lasting antibody responses compared to vaccination alone, in the long term as well. In terms of age groups in vaccine group, <20 group show the greatest infection risk following >60, 40-60 and 20-40. All these differences accounted for heterogeneous individual vaccine responses and individual levels of exposure. Importantly, antibody decay was clearly observed after 6th month from the last immunological events for the vaccine group (more quickly for the>60 age group but greater magnitude for the <20 group) compared to hybrid groups.

**Conclusion**: Our results indicate that vaccination campaigns should be tailored according to individual immune status, previous history of SARS-CoV-2 infection, and characteristics of the population risk factors (age, gender) to achieve optimal responses and protection across individuals.

**Introduction**

Natural SARS-CoV-2 infection and vaccination against COVID-19 both contribute to building the population’s immunity. Immune responses are multifaceted, but single components that are easy to measure, such as antibodies, are used in epidemiological studies to characterize the population-level immunity and the longevity of antibody responses induced after infection and/or vaccination. Studies of COVID-19 vaccines have shown waning immunity over time (after 2 doses), as measured by primarily decreasing antibody titers and vaccine effectiveness (breakthrough infections) [1, 2]. However, estimating the magnitude and durability of this protection in the population has become a challenge because of the surge in the omicron (B.1.1.529) variant, which has resulted in many individuals with hybrid immunity (immunity developed through a combination of SARS-CoV-2 infection and vaccination), varying rates and timings of past infection and vaccination, multiple types of vaccination and numbers of doses, and variants of concern that can escape pre-existing immunity [3]. Moreover, most existing seroepidemiological studies have focused on specific groups (e.g., healthcare workers), and the durability of antibody responses after infection and/or vaccination is less well explored within the general population [Ref???].

Systematic reviews of SARS-CoV-2 vaccine effectiveness studies have provided clarity on the durability of protection for different variants of concern [4, 5]. These studies have compared protection among vaccinated individuals to that in unvaccinated individuals and compared protection between different numbers of doses. Another recent systematic review estimated the durability of protection conferred by hybrid immunity and previous infection alone against multiple clinical outcomes of SARS-CoV-2 infection caused by the omicron variant [6]. This systematic review and meta-regression found that both previous infection alone and previous infection combined with previous vaccination (i.e., hybrid immunity) conferred rapidly waning protection against SARS-CoV-2 infection with the omicron variant but high and sustained protection against hospital admission or severe disease due to the omicron variant. The study also determined that previous infection was found to provide higher protection against reinfection and more sustained protection against hospital admission or severe disease than vaccination alone. Such a pattern might be explained by natural infection invoking a more diverse immune response to multiple antigenic sites on the virus compared to the immunity developed through vaccines that target only spike antigens. However, individuals with hybrid immunity had the highest magnitude and durability of protection against all outcomes, emphasizing the importance of providing vaccination to previously infected individuals. Infection-induced protection against reinfection wanes rapidly, and vaccination 564 increases durability.

To establish a protective threshold based on antibody levels, a 2021 study analyzed data from seven vaccines and convalescent cohorts to develop a predictive model [7]. This research estimated that a neutralization level equivalent to 20.2% of the mean convalescent level is necessary to achieve 50% protection against detectable SARS-CoV-2 infection. Furthermore, the study found that a significantly lower neutralization level, at 3% of the mean convalescent level, is required for 50% protection against severe infection. Another 2021 study, which involved a randomized efficacy trial of the ChAdOx1 nCoV-19 (AZD1222) vaccine in the United Kingdom, demonstrated that higher levels of immune markers correlated with a reduced risk of symptomatic infection, particularly against the Alpha variant. Specifically, 80% vaccine efficacy against symptomatic infection was associated with specific levels of anti-spike and anti-RBD antibodies, as well as pseudovirus and live-virus neutralization titers [8]. Additionally, another study from the same year provided a more detailed analysis of the trend in neutralizing antibody levels across different demographics, revealing that these levels declined rapidly within three months following the second vaccine dose, with significantly lower titers observed in men, older adults, and immunosuppressed individuals six months post-vaccination compared to women, younger adults, and those without immunosuppression [9].

Earlier research into the mechanisms of vaccine-induced immunity also suggested that vaccines which elicit high levels of virus-neutralizing antibodies are likely to be the most effective in preventing infection and mitigating adverse outcomes [10]. Moreover, the research from Earle et al. underscores the urgent need for a correlate of protection (CoP) to accelerate the development of additional COVID-19 vaccines [11]. By evaluating the relationship between vaccine efficacy and in vitro antibody titers from seven vaccines, they found strong correlations between neutralizing titers and efficacy (ρ = 0.79) and between binding antibody titers and efficacy (ρ = 0.93).

In South Korea, a large majority of the population has either hybrid or vaccine-induced immunity, with only 7.6% having previous infection alone and 9.9% with no immunity. When the Omicron variant emerged, the presumed population immunity was between 80% and 85%, although nearly half of the children were estimated to have no immunity [12]. In this study, we directly compared anti-S levels and the relative incidence of breakthrough infections between groups with hybrid immunity and those with vaccine-induced immunity, given that neutralizing antibodies are a subset of spike (S) antibodies. We utilized data from a nationwide community-based cohort, allowing for large-scale analysis across various age subgroups. This cohort enabled us to conduct follow-up assessments with repeated antibody testing in August and December 2022, alongside detailed demographic and clinical characterization. The objectives of this research are threefold: First, we assessed the variation in anti-S antibody waning following the last immunological event across different age subgroups, comparing hybrid immunity with vaccine-induced immunity. Second, we evaluated the protective efficacy of these two groups over time, specifically focusing on the probability of remaining free from COVID-19 infection. Third, we examined the overall impact of anti-S antibody levels on the probability of remaining infection-free, comparing the effects across age groups between hybrid and vaccine-induced immunity cohorts.

# **Methods**

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## **Sample Collection and Definitions.** A nationwide community-based surveillance study was conducted from August to December 2022, during the 6th and 7th epidemic peaks of COVID-19 in South Korea. This study involved 258 public health centers and 113 private medical facilities across 259 cities and counties. A representative sample of 10,000 individuals aged 5 and older was randomly selected from 5,000 households. Data collection was conducted through one-on-one interviews by trained surveyors using tablets to ensure accuracy. More detailed descriptions of the cohort study design and data collection methods are published elsewhere (REF).

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Figure 1: Flow Chart Illustrating the Cohort Study Design

**Inclusion/Exclusion and matching criteria.** In this analysis, we defined the cohort by the following four distinct immunity types: hybrid-induced immunity (*S*+*N* +), vaccine-induced immunity (*S*+*N−*), infection-induced immunity (*S−N* +), and naive (*S−N−*) [13, 14]. Notably, the hybrid-induced and vaccine-induced immunity groups comprised over 98% of the cohort population (Figure 1). Consequently, subsequent research focused primarily on these two groups. The demographic and clinical characteristics of the two groups are described in Table 1.

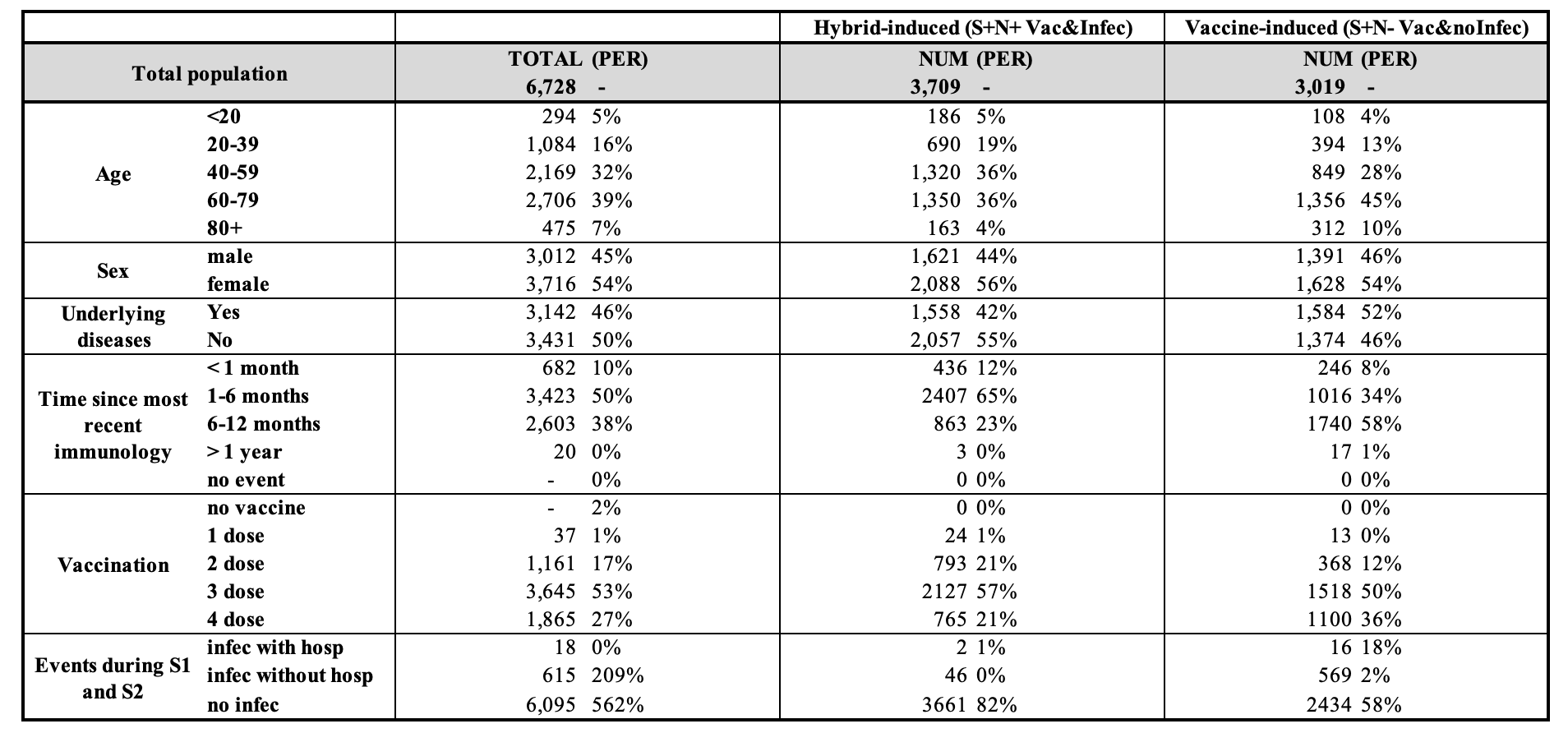


Table 1: Summary table of cohort study design

We analyzed two primary outcomes: S antibody levels at the first and second surveillance points (Figure 2) and the occurrence of infection events between these points (Figure 3). To ensure the validity of our assessment of S antibody levels on COVID-19 protection (Figure 3), we implemented rigorous exclusion criteria. Individuals not participating in the second survey and those vaccinated between surveillance periods were excluded to maintain the relevance of initial S antibody levels. We employed a nested case-control (NCC) design [15, 16], matching cases and controls by age and S antibody levels while treating other characteristics as potential confounders. This approach ensured robust comparisons and controlled for confounding variables in the logistic regression model.

**Statistical analyses**. We began by conducting descriptive analyses to generate trajectory plots that track the average changes in S antibody levels across different immunity groups and age subgroups following immunological events. This allowed us to visualize the dynamic changes in antibody levels over time. Following this, we performed Kaplan-Meier survival analyses to compare the protective efficacy of the two primary immunity groups, focusing on the probability of remaining free from COVID-19 infection after the initial surveillance period. The outcome within each group was defined as the infection status during the first and second surveillance periods. To address potential imbalances in the case-control data and to control for confounding variables, we implemented the nested case-control (NCC) method using the R package ‘Epi’ [17], adjusting the matching ratio from 1:6 to 1:3 between cases and controls. This adjustment was made based on the recommendations of Pearce [15] to optimize the balance between statistical power and practical feasibility. Furthermore, we employed Cox proportional hazards regression to investigate the effects of various variables on survival time, adjusting for potential confounders to provide a more comprehensive understanding of the associated risk factors. Finally, mixed-effects logistic regression models were used to evaluate the protective efficacy, defined as the probability of remaining infection-free, associated with S antibody levels across different immunity and age subgroups. This comprehensive approach allowed us to rigorously assess the impact of S antibody levels on COVID-19 protection across diverse populations.

**Results****.** The trajectory plots of S antibody levels indicate that individuals in the hybrid-induced immunity group exhibit higher overall S antibody levels compared to those in the vaccine-induced group. Specifically, the hybrid group is able to maintain elevated S antibody levels (exceeding 10,000) for up to one year, whereas the S antibody levels in the vaccine-induced group decline below 5,000 within six months post-vaccination. Within the hybrid group, S antibody levels are slightly lower in individuals under 20 and over 60 compared to those aged 20-60. In contrast, there is no significant difference across age groups within the vaccine-induced group.

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Figure 2: Trajectory plot for different age groups

The Kaplan-Meier survival analysis (Figure 3) demonstrates the survival probabilities, interpreted as the likelihood of remaining free from COVID-19 infection, over time for populations with vaccine-induced and hybrid-induced immunity. The analysis reveals substantial differences in survival probabilities between these two types of immunity across various age groups. Individuals with hybrid-induced immunity consistently exhibit higher survival probabilities, maintaining a rate of 98% over one year, compared to those with vaccine-induced immunity, whose probabilities decrease to 50-60% over the same period. Antibody decay is notably observed after the sixth month following the last immunological event for the vaccine group, with a more rapid decline in those over 60 and a greater magnitude of decline in those under 20 compared to the hybrid group.

When integrating the results from the trajectory plots and Kaplan-Meier survival analysis, it becomes evident that hybrid-induced immunity can sustain high S antibody levels (over 10,000) for one year before decreasing to 7,000, whereas the S antibody level in the vaccine-induced group falls below the 5,000 thresholds within six months post-vaccination. These patterns align with the survival curves, as the probability of survival in vaccine-induced groups declines rapidly after six months. This suggests a strong correlation between S antibody levels and survival probabilities.

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Figure 3: Survival Plot for Hybrid-induced and Vaccine-induced Groups

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Table 2: Cox Proportional Hazards Regression Results

The hazard ratio (exp(coef)) for hybrid group is significantly low as 0.09, indicating hybrid-induced immunity reduces the risk to approximately 9% of that for vaccine-induced immunity. For the, a hazard ratio of age groups>20 show 42-69% lower risk of infection than age <20 group with increasing risk trends with older age groups.

The probability of remaining infection-free by S ab levels across immunity/age groups shows similar risk trends by immunity/age groups with the survival analyses. In the vaccine-induced group, the probability of remaining infection-free decreases with higher S antibody levels across age groups, demonstrating the highest risk for age <20 (60% of remaining infection-free with S ab level 5000 to 75% with 250,000) following >60, 40-60, and 20-40 groups In other words, to have an 80% probability of remaining infection-free, age 20-40 requires an S ab level of at least 10,000, 40-60 groups as 150,000, and >60 as 20,000 and <20 as 250,000. However, in the hybrid-induced group, whatever the age group and S ab level, the population maintain over 95% of remaining infection-free during.

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Figure 4: Regression line comparison for vaccine-induced (left) and hybrid-induced (right) groups

# **Discussion**

Our study examined the protective effectiveness of COVID-19 infection across age group between hybrid and vaccine-induced in general population based on community-based nationwide surveillance. In this study, we utilized nationwide community-based surveillance data (large sample sizes and wide age spectrums) from South Ko- rea, involving 10,000 participants, with detailed demographic information and serological assessment twice after an epidemic wave of omicron variants. We defined the hybrid and vaccine group based on information from serology (S and N status) and self-reporting on previous vaccination and testing as accurately as possible, avoiding many sources of bias that would lead to differential misclassification of people as infected. We illustrated the S antibody level and associated protective efficacy against breakthrough infection over time by age group and immunity status. Based on the identified risk factors by the immunity groups, we quantified the probability of free from infection risk by age group so it can guide the specific vaccine prioritization and interval for age groups.

Our study highlights significant differences in the efficacy of hybrid-induced and vaccine induced immunity in preventing COVID-19 infections across various age groups, which correlated with higher initial S antibody levels; After the Omicron wave, our data shows the highest breakthrough infection risk is younger (<20 age) vaccine group, following >60, 40-60 and 20-40. The high risk for younger (<20 age) may be due to the increased exposure/contacts after omicron waves with the lift of the social distancing policy. This suggests that under new variants with the relaxation of measures across many countries, groups previously less exposed, for example, due to shielding guidance, may become more at risk. In addition to assessing the risk of infection, we also investigated the risk of hospitalization among those infected. While the hospitalization events were quite small (which limited sample size precludes more detailed statistical analysis), the result indicates that the Infection hospitalization risks are higher for vaccines especially for age > 60 after omicron waves. (Appendix Table S1) The high risk for older (>60 age) may be due to the decreased immune system efficiency with age (as known as immunosenescence). Previous studies showed individuals 60 years or older had lower antibody levels after vaccination compared to younger participants and increased age has been associated with reduced vaccine responses in a number of studies irrespective of vaccine type [18]. A similar effect has been seen with antibody responses after infection. On the other hand, another study showed no consistent associations of lower antibody levels with age, but a very strong age gradient (lower incidence with older age) of post-vaccination infection based on cross-sectional samples from Apr 2021-Jan 2022 before omicron wave. Overall, these results are consistent with the risk of infection being a complex combination of SARS-CoV-2 case prevalence, individual immune response to vaccination, and individual level of exposure [19].

Our findings indicate that the need for and timing of booster doses may differ for individuals with hybrid immunity compared to those with vaccine-induced immunity, with the possibility of delaying booster doses by six months for those with hybrid immunity while still maintaining strong protection against severe disease. On a broader scale, the optimal number of vaccine doses and intervals may vary depending on the prevalence of vaccine-induced versus infection-induced immunity within a population, suggesting that booster strategies should account for both vaccination history and previous infections, alongside the clinical characteristics of those infections. Further research is needed to better understand the interaction between natural and vaccine-induced immunity, the effects of variant exposure, and the timing between exposures. These insights can help policymakers project population-level protection using local vaccination and seroprevalence data, thus informing the strategic use and timing of COVID-19 vaccinations as a vital public health tool.

Our study has some limitations. Firstly, our analysis did not account for the sequence permutations and timing between vaccination and prior infection in individuals with hybrid immunity. As a result, the relative protection levels observed (specifically, the waning of S antibodies in the hybrid vs. vaccine-only groups) may vary depending on subgroup distributions and calendar time, including variant types and the epidemic stage, as noted in Bobrovitz’s research. While the relationship between neutralizing antibody levels and protection is generally robust, variants such as Beta require significantly higher antibody titers to achieve the same level of protection as the original strain. Additionally, we measured binding antibodies rather than neutralizing antibodies, which are arguably a better surrogate for immune protection. The antibody assays used in our study were developed before the emergence of Variants of Concern (VoCs), raising questions about whether these assays, based on the original Wuhan-Hu-1 strain, accurately capture infections with other variants—a matter that should be evaluated in ongoing seroepidemiological studies. Potential sources of misclassification bias include the decay of neutralizing antibodies, the sensitivity and specificity of antibody testing, and the timing of testing relative to infection and vaccination. Furthermore, unmeasured bias in exposure may stem from the observational nature of the study, where individuals who chose to get vaccinated or had previous infections did so at different times, without controlling for possible differences in healthcare-seeking behavior or risk aversion among participants.

**Conclusions**

In summary, in this large cohort study, we compared the antibody responses and their infection risks induced by different COVID-19 immunity statuses (hybrid and vaccine) across age groups. We showed that S ab waning and risk infection trends are highly correlated; hybrid group resulted in higher and longer-lasting antibody responses compared to vaccination alone, in the long term as well. In terms of age groups in vaccine group, <20 group show the greatest infection risk following >60, 40-60 and 20-40. All these differences accounted for heterogeneous individual vaccine responses and individual levels of exposure. Importantly, antibody decay was clearly observed after 6th month from the last immunological events for the vaccine group (more quickly for the>60 age group but greater magnitude for the <20 group) compared to hybrid groups. In the hybrid group, however, 4th booster vaccines have a significantly higher infection risk than the primary vaccine group, highlighting the continuous vaccine compliance in this group.) Moreover, in addition to the S ab level and infection risk trend over time by age group, we quantified the probability of free from infection risk by age group so it can guide the specific vaccine prioritization and interval for age groups. Taken together, our results indicate that vaccination campaigns should be tailored according to individual immune status, previous history of SARS-CoV-2 infection, and characteristics of the population risk factors (age, gender) to achieve optimal responses and protection across individuals.

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Based on the key demographic characteristics (Table 1), we conducted logistic regression to determine specific risk factors on infection events for hybrid and vaccine groups, respectively. All available characteristics were converted to categorical variables, with the first subgroup designated as the reference category. This al- lowed for the calculation of log odds ratios, where a higher log odds ratio indicates a greater infection risk compared to the reference group. A log odds ratio of zero signifies equal risk with the reference group.

Among all characteristics, age and S antibody level demonstrated the most significant association with individual infection status, exhibiting clear patterns and non-overlapping con- fidence intervals. (Figure S1) Notably, the youngest group exhibited the highest individual infection risks. Except for the youngest group, there was a positive correlation between age and infection risk, indicating that risk increases with age. In order to determine the risk probability of remaining infection-free by S antibody levels across age groups, we constructed logistic regression including age only based on the finding. (Figure 4 and S2)

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* + 1. Hybrid-induced group

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* + 1. Vaccine-induced group

Figure S1: Forest plot displaying characteristic patterns: Top - Vaccine-induced group; Bottom - Hybrid-induced group

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Figure S2: ROC curves for logistic regression models

The ROC curve analysis demonstrates that the mixed-effects logistic regression model (red curve) exhibits superior discriminative capability compared to the simple logistic regression model (blue curve). This conclusion is supported by the consistently higher position of the mixed-effects model’s ROC curve across all threshold levels. Moreover, the mixed-effects model achieves a higher Area Under the Curve (AUC) value of 0.82, in contrast to 0.77 for the simple logistic model. This indicates a marked improvement in the mixed-effects model’s performance in predicting the binary outcome, thereby suggesting its enhanced utility in applications requiring robust classification accuracy.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | <20 | 20-40 | 40-60 | >60 | Total |
| Hybrid | Infections | 4 | 6 | 20 | 17 | 48 |
| Hospitalization | 0 | 0 | 0 | 2 | 2 |
| Infection hospitalization risk | **0.00** | **0.00** | **0.00** | **0.14** | **0.04** |
| Vaccine | Infections | 43 | 83 | 178 | 281 | 585 |
| Hospitalization | 1 | 1 | 3 | 11 | 16 |
| Infection hospitalization risk | **0.02** | **0.01** | **0.02** | **0.04** | **0.03** |

Table S1. Infection hospitalization risks by immunity status and age groups.